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EDITORIALS

U. S. SUPREME COURT'S OPINION ON GUILT OF AMERICAN MEDICAL ASSOCIATION AND MEDICAL SOCIETY OF DISTRICT OF COLUMBIA, IN "GROUP HEALTH ASSOCIATION" CASE

An Important Opinion, For Both the Present and Future.—On January 18th, the Supreme Court of the United States handed down its unanimous opinion, that the two petitioners (American Medical Association and Medical Society of the District of Columbia) who, in a jury trial in a lower court, had been fined $2,500 and $1,500 respectively, were given a fair trial on the charge of conspiring against "Group Health Association, Inc.," of the District of Columbia, in violation of the Sherman Antitrust Act of 1890—and that the judgments should stand affirmed.

This much discussed case was started in 1937 when a grand jury, in the District of Columbia, brought in an indictment against the two organizations and certain officers thereof and individual physicians. In the initial trial, the Washington District Federal Court ruled in favor of the medical societies and members involved, but this decision was reversed by the District Court of Appeals. The jury trial and judgment for penalties then followed.

The American Medical Association and Medical Society of the District of Columbia thereupon petitioned the United States Supreme Court to not affirm the judgments previously rendered in the lower court. However, on January 18, 1943, the Supreme Court of the United States affirmed the guilt of the two medical societies.

* * *

Court's Opinion Has Broad Implications.—Concerning the opinion handed down by the Supreme Court, it can be said that it has implications more far-reaching than may be at first thought. Justice Roberts, who wrote the opinion, used language applying in its scope not only to the case before the Court, but also to similar cases such as may arise in any State in the Union; in the profession of medicine, and possibly, also, in the legal and other professions.

It is most important that organized medicine, as represented in state and component county medical societies, shall henceforth be on the alert, and avoid procedures and actions that may make them amenable to like judgments which could be entered in lower local courts, where the Supreme Court opinion would probably be cited as final

authority. Therefore, it may be worthwhile to consider briefly some aspects of this now celebrated case. The full opinion appeared in the *Journal of the American Medical Association,* January 23, 1943, on page 267, and members may find its perusal of interest.

* * *

Court's Permission to Submit An Appeal.—When the Supreme Court permitted the appeal to be listed for its consideration, it seemed that the following issues would be considered:

1. Whether the practice of medicine is a "trade" within the meaning of the Sherman Act of 1890, or whether, as a profession, it is exempt from the said Act.

2. Whether the charges made in the indictment were proved.

3. Whether the Norris-LaGuardia Act relating to antiinjunctions and the Clayton statute concerning antitrust actions, barred prosecution.

* * *

Court's Opinion after Hearing the Appeal Arguments.—In its opinion, rendered on January 18th, the Supreme Court stated, in essence, that it found:

(a) That the charges of violation of the Sherman Antitrust Act of 1890 were warranted;

(b) That a fair trial had been held;

(c) That the question, whether the practice of medicine was a profession or trade was not a matter in issue;

(d) That the labor acts (Norris-LaGuardia and Clayton statutes) did not apply in the instant case;

(e) That "Group Health Association, Inc.," which was brought into being in 1937 by "Home Owners' Loan Corporation"—an organization of some 2,500 Government employees who were in coöperation to provide medical care and hospitalization services for their members through its own staff of physicians, in return for monthly payments or dues into a common fund created for such purpose—was in fact a "membership corporation engaged in business or trade";

(f) That the American Medical Association and the Medical Society of the District of Columbia had

"induced and coerced their members to boycott Group Health Association by refusing to serve on its staff or to consult with doctors on its staff, and induced and coerced all the hospitals in the District of Columbia, not operated by the Government, to boycott Group Health Association by denying hospital privileges to doctors serving on its staff . . . ;"

(g) That the A.M.A. and its constituent unit, the Medical Society of the District of Columbia had

"combined and conspired to restrain Group Health Association in its business of providing medical care and hospitalization, to restrain the doctors on its staff, as well as other doctors, in the pursuit of their callings, and to restrain Washington hospitals in the operation of their business . . . ;"

(Editor's Note. Referring to "coercion" mentioned in the Court's opinion, it may be permissible to assume that, in part, the same referred to the procedures and supposedly prohibitive actions taken by the A.M.A. and/or the District Medical Society against any member who would be found serving on the Group Health Association staff, or consulting with its members, the penalty for such service or consultation being threat or pain of expulsion from the Medical Society of the District of Columbia; and also the steps taken to prevent staff members of Group Health Association from utilizing the facilities of hospitals located in the District of Columbia);

(h) The Court found that the A.M.A. and District Medical Society had practiced "coercion" and that the said actions did fall within the scope of the Sherman Antitrust Act of 1890,

"whether the conspiracy was aimed at a restraining or destroying competition, or had as its purpose a restraint of the free availability of medical or hospital services in the market."

It was on the above points that the Supreme Court of the United States affirmed the judgments of the lower court.

* * *

Some Deductions from the Supreme Court Opinion.—If the above comments are correct, it may be in order to emphasize how important it is that no medical society shall approve resolutions or take actions similar in nature to those which brought so much trouble and expense to the American Medical Association and the Medical Society of the District of Columbia.

As we understand it, there is nothing in the Supreme Court decision that should prevent a medical society from laying down the qualifications which must be possessed by applicants for membership, so long as they relate only to legal licensure and individual qualifications of professional or moral nature.

And, in similar degree, the governing or medical authorities of a hospital should be permitted, as heretofore, to adopt rules for staff membership and utilization of hospital facilities that have, as their purpose, not only the protection of health and lives of patients, but the good name of the institution in its own community. In other words, the institution shall have the right to approve all proper procedures that will make for the protection of patients from incompetent practitioners of medicine and surgery, or that will promote its own standards of adequate medical and hospitalization care.

* * *

Relation to County Society Disciplinary Procedures.—Another thought, in connection with what took place in relation to the District of Columbia case here receiving comment, concerns disciplinary procedures by medical organizations. It cannot be too strongly emphasized—while a medical organization like any club or other organization, has the right to set up its own qualifications for membership—that once a physician

becomes a member, he establishes rights for himself, akin almost to property rights, and his membership cannot be jeopardized or taken from him, except after fair trial, and in which all by-law procedures have been meticulously observed. In every such disciplinary case before a medical organization, it is mandatory that any penalties that may be approved, shall be handed down in full accord with by-law provisions.

And, attention may be called to the provisions in the by-laws of the California Medical Association, whereby it is mandatory upon all component county societies that the disciplinary procedures outlined in Chapter II shall be observed. County Societies which have not made the necessary revisions in their own by-laws should do so promptly.

WILL TAXATION OF CALIFORNIA'S NONPROFIT HOSPITALS IMPERIL THEIR CAPACITY FOR SERVICE?

Court Case of Seaside Hospital.—Excerpts from a case of first impression, in relation to placing nonprofit hospitals within the scope of the California Unemployment Insurance Act appeared in the January issue of CALIFORNIA AND WESTERN MEDICINE (on page 38).

The decision referred to was handed down by Judge Emmet H. Wilson of the Superior Court of the State of California in and for the County of Los Angeles, the case being one that concerns the Seaside Memorial Hospital of Long Beach, a nonprofit corporation.

However, the issues involved affect many other nonprofit hospitals now operating in California—with their possible future capacity for charitable work at stake,—and they also have relation to the interests of physicians who use the facilities of the hospitals.

Judge Wilson's opinion is in contradiction to the views held by the State bureau known as the California Unemployment Commission and, unless remedial legislation is enacted, the points laid down by him will remain in question pending appeals to the higher courts of the State. In the meantime, between fifty to one hundred nonprofit California hospitals may find themselves involved in court litigation on whether they have a tax-exempt status.

* * *

Basis of the Commission's Contention and Judge Wilson's Opinion.—The controversy seems to hinge around the claim of the California Unemployment Commission that no hospital in this State may qualify as a charitable institution unless at least fifty per cent (50 per cent) of its work is charity. As is well known, California hospitals, have not been, as a class, the recipients of heavy endowments that would permit extensive charity work; at least not to the same extent as similar institutions in older Eastern States. However, many of the California hospitals have been incorporated as nonprofit organizations, an excellent evidence of their intention to do as much charity work as their respective incomes will permit.

When the Seaside Hospital of Long Beach was notified that the California Commission was levying the tax, it secured the coöperation of the Association of California Hospitals, it being necessary to carry the court proceedings to the California Supreme Court before Superior Court Judge Wilson was permitted to place the case on his calendar for trial. As stated above, excerpts from his decision in favor of the Seaside Hospital appeared in the January issue, on page 38, and one portion thereof is so much in accord with the views held by many physicians that it is here given for readers who may have missed the item:

Petitioner's claim of exemption under section 7 (g) of the statute. . . .

In order to do charity petitioner must have funds. It is not necessary that a charitable organization originate from or be maintained by means of bequests, donations, and offerings from public moneys, nor need its representatives go on the streets with coin boxes or tambourines soliciting passers-by in order to supply its treasury. It may collect from those who are able to pay for services rendered to them and use the remaining surplus in its charitable work without loss of its status as a charitable corporation. . . . Neither a certain defined amount of its expenditures for charity nor the percentage thereof in relation to its income or to its other expenses is the criterion. Not all of the patients need be treated free of charge. The number of free beds maintained by petitioner is only relative and is not important. There is no restrictive terminology in the statute from which it can be inferred that the legislature intended that a charity must be extensive in order to qualify under the law. To tax a nonprofit hospital is to place a direct tax on the sick and injured. The stipulated facts and the applicable law demonstrate that petitioner is organized exclusively for charitable purposes, that it is operated exclusively for such purposes, that no part of its net earnings inures to the benefit of any private shareholder or individual, and that by reason of the provisions of section 7 (g) of the act it is exempt from taxation under the statute and from the jurisdiction of respondents.

The action of the California Commission is the more difficult to understand because these nonprofit hospitals have thus far been held to be exempt under the Federal Income Tax and the Federal Social Security Act. A change in California status might lay the foundation for Federal taxation of them in the future and still further endanger their capacity for service.

* * *

Proposed Remedial Legislation.—To clarify the situation, a referendum measure has been submitted to the California Legislature now in session, and in due time will be placed before the voters for decision. It will be known as Assembly Constitutional Amendment No. 17, and was sponsored by 70 Assemblymen! Also, an amendment to the California Unemployment Insurance Act was introduced at Sacramento, and if it receives the approval of the Legislature and Governor, it should bring about a betterment in the situation

that has arisen through the Commission's rulings. The proposed amendment follows (portion to be amended is in italics):

PROPOSED AMENDMENT OF SECTION 7 (G) OF THE CALIFORNIA UNEMPLOYMENT ACT

(g) Service performed in the employ of a corporation community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children, or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, *including a nonprofit corporation or association, the articles of incorporation or association or by-laws of which forbid the distribution of any of its funds, revenues or other assets to any of its members as dividends or upon dissolution or otherwise, and which is not availed of for any such purpose, and which owns and operates a hospital, the facilities and services of which are available to the general public, and all of whose funds and revenues are devoted exclusively to the operating expenses, retirement of indebtedness and the improvement of such hospital or to other benevolent or charitable purposes.*

In the meantime, physicians who are staff members of nonprofit hospitals may desire to contact their administrative boards, in order to remain in better touch with the problem.

* * *

An Analagous Issue in New York.—Of collateral interest in connection with the above is a news item noticed on the day of this writing, from which the following excerpt is taken. (For complete text, see in this issue, on page 95):

"Like countless other charitable, educational and religious institutions in America, this hospital (New York Infirmary for Women and Children) probably would never have been created or maintained in a country which had limited opportunity in individual money making efforts.

"The board unanimously agreed that institutions like the Infirmary may be permanently crippled if contributions were withdrawn by individuals affected by the new ruling."

Perusal of the above statement raises the query —Is it not, perhaps, a short-sighted policy to institute governmental measures which, when carried through, result in stifling donations that otherwise might be made for the betterment of the public welfare and health; or which, through burdensome taxation, prevent nonprofit institutions from maintaining or extending their charitable work in behalf of many citizens in need thereof?

ON VARIOUS TOPICS

Charles B. Pinkham, M. D. Retires as Secretary of the Board of Medical Examiners of the State of California.—A large number of the physicians now practicing in California have met Doctor Charles B. Pinkham, since January, 1913, a member of the Board of Medical Examiners of the State of California, and who also acted as its secretary from that date—his service in this capacity covering a period of some thirty years. Doctor Pinkham's record is notable, not only because of its long, continuous term, but also because of the conscientious and able manner in which he has carried on this important work during the last three decades.

Many members of the profession do not appreciate the onerous nature of the duties and responsibilities which fall to the lot of colleagues who are willing to take over the obligations which go with membership on a State Board of Medical Examiners. Of special importance to a properly functioning Board is the physician who acts as its executive officer. It is he who is constantly called upon to safeguard the interests of medical standards, and to counter the endeavors and onslaughts of those who would seek licensure to practice without fulfilling to the last degree, the requirements laid down in the Medical Practice Act. It is to the great credit of Doctor Pinkham, who has submitted his resignation to Governor Warren—because he has now reached the retirement age—that succeeding Boards of Examiners have been unanimous in their praise of the important investigative and other work which he has graciously and efficiently carried on.

Doctor Pinkham received his A. B. degree from Stanford University, and his M. D. in New York. He was registered in California in 1900, succeeding to his father's medical practice in Sacramento in 1901. It has been his privilege to serve under Governors Hiram Johnson, William D. Stephens, Friend W. Richardson, C. C. Young, James Rolph, Jr., Frank Merriam, Culbert L. Olson, and Earl Warren.

During these thirty years, Doctor Pinkham has been instrumental in taking the lead in many efforts to maintain medical standards. Particularly may be mentioned his endeavors in relation to elimination of quack specialists for men; diploma-mill activities; fraudulent medical licenses issued by some of the State Medical Examining Boards and the endeavors of the holders thereof to secure California medical licenses; eradication of the Pacific Coast Abortion Ring; extirpation, with the assistance of Postal Inspectors of a nation-wide ring of eyesight swindlers; and coöperation with the Federal and State authorities in suppression of narcotic irregularities.

As Doctor Pinkham retires for well-earned rest, he has the good wishes of members of the California Medical Association; who also hope that a successor, equally well qualified, may be found to take over his duties.

Amendments to Medical Practice Act of California.—Editorial and other comment on proposed amendments to the medical practice acts of many States of the Union was given in the January issue of CALIFORNIA AND WESTERN MEDICINE (pages 2 and 36), and in the current issue appears a copy of a letter addressed to the American Federation of State Medical Boards by the Oklahoma Board of Medical Examiners (page 80). A perusal of the queries in last month's JOURNAL, and the Oklahoma letter, should be

sufficient to indicate that the proposal for widespread amendments to medical practice acts is neither simple nor devoid of danger to medical standards.

For the information of members of the California Medical Association, it may be stated that the members of the C.M.A. Council gave the subject of amendments to the State's Medical Practice Act careful consideration. The conclusion was reached that certain simple amendments, suggested by the Board of Medical Examiners would make it possible for that Board to meet any emergencies that might arise. The proposed amendments will make for simpler procedures in giving examinations, which also may be more frequently held. It is believed these will answer medical service needs, and without endangering California's established standards.

California's 55th Legislature in Recess during February: Proposed Legislation.—This year, under existing war conditions, even the California Legislature is holding what may be called a modified, streamlined gathering. The 55th session convened on Monday, January 4th and by the constitution could remain in session for not exceeding thirty days; then to recess for not more than thirty days. The Legislature is booked to reconvene on Monday, March 8th.

At this writing, it is not possible to present to readers a complete list of all proposed legislation having direct or indirect relationship to public health and medical matters and standards. A partial list appears in this issue on page 79. The committees on public policy and legislation of the county medical societies should scan the above lists and also any others that may be sent.

In the January number, on pages 35 and 36, the rosters of the two legislative houses were printed, the home addresses of State Senators and Assemblymen being given. It may be desirable to preserve the lists for future use and reference. (A summary on legislation of medical interest, presented to the U. S. Congress in the year 1942, appears on page 74 of this number of CALIFORNIA AND WESTERN MEDICINE.)

It is too early to state with positiveness what struggles may come to the front on legislation in which medicine and the associated professions have natural interests. When the 55th Legislature again convenes on March 8th, the legislators will take up in earnest the consideration of proposed laws. Fortunately, the medical profession does not have before it, a menace such as confronted it some four years ago, when the then Governor espoused a Compulsory Health Act as an item of "must legislation," that was to be enacted forthwith, willy nilly. For the defeat of that project, physicians of California may continue to render thanks.

In due course, bulletins will be sent to the component county societies, informing them concerning the more pertinent matters, and indicating procedures on appropriate lines of desirable action. In the meantime it will be wise procedure if county societies, their officers and committees, and also members, refrain from giving endorsements to proposed legislation, except as such may be requested by the C.M.A. Committee on Public Policy and Legislation of which Doctor Dwight Murray of Napa, is chairman. This in accord with past action of the C.M.A. House of Delegates. (For Committee roster, see adv. page 2.)

EDITORIAL COMMENT†

OSTEOPATHIC AND CHIROPRACTIC IMMUNOLOGY

Experimental evidence of the nonexistence of the alleged "immunity center" in the brain, the theoretical basis of much of osteopathic and chiropractic therapy, is currently reported by Stanton[1] and his coworkers of the New York State Psychiatric Institute.

The first serious suggestion of a neurological integration of specific immunity came from a study of the effects of certain drugs on serum titer. Some of these drugs were known or assumed to act primarily on the central or peripheral nervous system. Both increases and decreases of specific antibody production were reported, sufficient to make plausible the existence of a specific "immunity center" in the brain.

Metalnikov,[2] and Diacono,[3] and others attempted to confirm this plausibility by a study of immunologic conditioned reflexes. Animals were given an electric shock or other conditioning stimulus immediately before injection of heat-killed bacterial vaccines or alien erythrocytes. After numerous repetitions of this association, the rabbits showed a significant rise in homologous antibody titer on application of the conditioning stimulus alone. Few if any controls were tested. Using a large number of animals with adequate controls, Kopeloff[4] and his colleagues were unable to confirm these findings. In their hands fluctuations in agglutinin nitrogen were almost identical in conditioned and normal control animals.

Other investigators attempted to confirm the neurogenic origin of specific antibodies by "antigen depot" experiments. Schamburow,[5] for example, injected nonviable typhoid vaccine into the anterior chamber of the rabbit eye. He found the specific agglutinin titer of the aqueous humor of the injected eye increased to 8-fold that of the synchronous agglutinin titer of the blood stream. This he accepted as proof of a local synthesis of specific agglutinins in the injected eye. Studying the opposite, nonvaccinated eye, he often found

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

an agglutinin titer 2 to 3 times that of the blood stream, conclusive evidence from his point of view of a reflex local synthesis of specific typhoid agglutinins in the nonvaccinated eye. This he believed could only be brought about through a specific "immunity center" in the brain. The experimental data for this conclusion, however, could not be confirmed by Madison[6] and other American investigators.

In contrast with these contradictory results, experiments involving destruction of certain parts of the nervous system have given consistent data. Metalnikov,[4] for example, found that specific anticholera immunity could be produced in certain caterpillars by the injection of heat-killed cholera vaccine. Destruction of the third thoracic ganglion in these caterpillars, however, prevented the development of this specific immunity, destruction of other ganglia having little or no inhibiting effect. Bogendörfer[7] sectioned the spinal cord of dogs usually at the 6th cervical vertebra, control animals being sectioned in the lower thoracic region. All control (low spinal section) animals produced specific agglutinins on injection with bacterial vaccines. Practically no agglutinins were formed by the high-level (cervical) spinal-section dogs. This clearly suggested to him the existence of a neurogenic immunity center, interrupted by high-level spinal cord section.

Stanton and his coworkers attempted to confirm this high-level immunologic paralysis, using white rats as the experimental animals. Rats were selected because of negligible mortality with adequate postoperative care. Groups of from 10 to 20 rats were sectioned between the 1st and 2nd thoracic vertebrae. An equal number of "operated controls" were sectioned between the 6th and 10th thoracic vertebrae. The animals were placed in a warm-box until recovery from the operation. Five to 14 days after recovery both groups, together with an equal number of "nonoperated controls," were given an intraabdominal or intravenous injection of a standard dose of washed sheep erythrocytes. The animals were bled 7 days later, and the antisheep hemolytic titer of each animal estimated with the aid of guinea-pig complement. In a typical experiment, 23 out of a group of 28 nonoperated controls yielded serums with amboceptor titers often as high as 1:2560. Ten of the 13 low-level "operated controls" yielded antiserums with a maximum titer of 1:1280. Among the 19 animals with high thoracic cord section, 15 produced no demonstrable hemolysin. The remaining four gave traces of hemolysin (average titer 1:60). A similar almost complete suppression of specific antibody formation was recorded for all other high-level operated groups, seeming confirmation of the neurogenic theory of specific immunity.

Stanton and his colleagues, however, took cognizance of the fact that the observed "immunologic paralysis" is not the only effect of high-level spinal cord section. The high-level operated animals also lost their normal temperature control. Maintained at ordinary room temperature, their rectal temperatures often fell from the average normal of 34.5 C to 27 C or even lower. Before the existence of a specific "immunologic paralysis" could be deduced from their data, therefore, the possible deleterious effects of this subnormal body-temperature must be ruled out. To do this, parallel groups of high-level spinal cord sectioned rats were maintained at higher external temperatures. At 33 C external temperature the animals showed practically no fall in normal rectal temperature. In these animals antibody production was equal to that of the unoperated controls. This is conclusive evidence that high-level cord section in itself has no deleterious effect on specific antibody synthesis, the observed suppression of immunologic function being a secondary effect of subnormal body-temperature.

Fifty years ago, before the development of modern theories of humoral immunity, Sawtschenko[8] made a similar observation. He found that when the cervical cord was sectioned in pigeons, the birds lost their natural immunity to anthrax. This he attributed to their lowered body-temperature, avian resistance to anthrax then being attributed solely to their high normal body-temperature.

The alleged totalitarian "immunity center" in the brain initiating and coördinating specific antibody production has been of philosophic interest among European investigators largely on account of its political implications.[9] American clinicians, however, will probably find their main interest in its application to certain unofficial methods of clinical therapy. Hulburt,[10] of the American Osteopathic Association, for example, states that it is a basic tenet of osteopathic therapy that interference with spinal function causes "a resulting intemperance with the body's ability to make its own serum and antitoxins to fight infectious disease processes." This theory is endorsed in somewhat more picturesque language by Chiropractors,[11] who allege that as a result of spinal cord injury "the efferent nerves are prevented from transmitting to the various bodily organs the mental impulses necessary for their proper function (e.g., specific antibody production)." Disproof of the neurogenic theory of specific antibody production is, therefore, equivalent to disproof of one of the major basic tenets of both Osteopathy and Chiropractic.

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DIANTIGENIC INSULIN

An apparent confirmation of the newer theories of specific antibody production is seen in the clinical evidence of the existence of two distinct antibodies against crystalline insulin, recently reported by Lowell[1] of the Massachusetts Memorial Hospital.

The earlier immunologists assumed a one-to-one relationship between specific antigen and antibody, all observed allergic or immune phenomena being explained on this basis. The possibility that a single antigen may give rise to two or more different antibodies, however, would follow logically from the more recent template theory of specific antibody synthesis. According to this theory[2] specific antibodies are new-formed protein molecules synthesized intracellularly as "templates" of the injected antigen. Assuming that the antigen is asymmetrical in chemical structure, two or more different templates might be formed to fit its different poles. Moreover, homologous templates formed by different histological units might well be of different structure or function.

One of the best illustrations of the template theory is the recent demonstration by Smadel[3] and his coworkers of the Rockefeller Institute of the dual antigenicity of vaccine elementary bodies. Earlier investigators demonstrated the existence of two different soluble antigens in vaccine lymph,[4] a heat-labile (L) antigenic molecule, readily destroyed by heating to 56° C, and a heat-stable (S) molecule resisting heat to 95° C. There was suggestive evidence that in the elementary bodies the two antigens may be conjugated to form a single protein complex, a duplex LS-antigen capable of reacting equally well with anti-L and anti-S serum. The Rockefeller Institute biochemists isolated this hypothetical LS-complex from dermal pulp of cutaneously infected rabbits, and showed that it is a homogeneous protein of approximately the same molecular size as serum globulin. This protein is precipitated quantitatively with either anti-L or anti-S precipitin. They found that the L-pole of this native antigen can be partially (L') or completely (L") denatured by heat, without demonstrable alteration of the S-pole. By means of enzymic digestion the S-pole can be similarly degraded (S', S") without demonstrable injury to the L-pole. Dissociation of the LS-molecule into free L- and S-proteins, however, was not demonstrated.

The existence of diantigenic proteins affords a convenient explanation of numerous puzzling clinical phenomena. In 1929, for example, Cook and Spain[5] pointed out the lack of correlation between the skin-sensitizing and smooth-muscle sensitizing antibodies formed against the same alien protein. Somewhat later Loveless[6] demonstrated the existence of two antibodies against the same pollens. One of these was a thermostable, nonsensitizing antibody capable of binding pollen-protein, the other a thermolabile, sensitizing antibody presumably responsible for the observed allergic phenomena. Since ragweed pollen is known to be a complex protein mixture, no definite conclusion could be drawn from the observed apparent diantigenicity.

A year ago Yasuna,[7] of the Boston City Hospital, found 11 recorded cases of general sensitivity to crystalline insulin, adequately confirmed by allergy studies. A twelfth case was reported from his Diabetic Clinic, in which severe insulin allergy was associated with marked insulin tolerance. Mouse-test showed that 0.5 c.c. of the patient's serum would neutralize twice the convulsive dose of crystalline insulin. The neutralizing properties were not destroyed by heating the serum to 57° C for 2 hours. A 1:32 dilution of the same serum would passively sensitize normal human skin to crystalline insulin. The skin-sensitizing activity, however, was completely destroyed by heating the serum to 57° C for 2 hours. Lowell concludes from these and other data that "there were two antibodies in the patient's serum, an allergic antibody which is heat-labile and confers sensitivity on normal skin, and an insulin-neutralizing antibody which is heat-stable and was capable of destroying the physiological effects of crystalline insulin."

Insofar as crystalline insulin is a single protein molecule, it would seem logical to conclude that insulin protein is diantigenic, capable of stimulating the production of two functionally distinct antibodies. Insulin would thus be the latest addition to the rapidly increasing list of multiantigenic proteins of theoretical and practical interest. Other explanations of the dual antibodies (anti-insulins) are of course possible.

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ORIGINAL ARTICLES

Scientific and General

SULFATHIAZOLE REACTIONS IN TOXIC AND NONTOXIC INDIVIDUALS*

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SINCE sulfathiazole has been so effective in the treatment of various infectious conditions at the Station Hospital, Camp Haan, California, its undesirable side effects have become of increasing interest and importance to us. We had observed that these side effects seemed to occur most frequently in patients who were toxic and febrile from their illness and were apparently less common in the individual whose disease did not cause a toxic, febrile response, irrespective of the total sulfathiazole dosage or its length of administration.

In an effort to substantiate or disprove this observation, hospital records of the last 300 patients to receive a single course of sulfathiazole on all services at this hospital were reviewed. Cases where two or more courses of sulfathiazole had been administered with intervening intervals were purposely excluded from this series. Numerous such cases were encountered but were omitted due to our interest in the recent work of Lyons and Balberor,[1] and others.[2] We propose to report the incidence and our conception of the mechanism of sulfathiazole side effects in these cases at a later date.

These 300 cases differ somewhat from others previously reported[3] in that all patients were men, predominantly young and vigorous. The age range was from 18 to 52 years, with a mean of 25.1 years. It was found in these cases that side effects attributable to sulfathiazole occurred approximately five times more often in toxic, febrile individuals than in the atoxic, afebrile, with due consideration also being given to total drug dosage and its length of administration.

Sulfathiazole blood levels will not be cited in any of the cases here reported since no excessive concentrations were encountered and it seems generally accepted[4] that blood concentration is not important in the production of sulfathiazole side effects.

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Grateful acknowledgment is extended to Colonel C. Blance, M.C., Commanding; Major B. H. Henning, M.C., Chief of Surgery; Major G. A. Williamson, M.C., Chief of Orthopedics; Major W. B. Brown, M.C., Registrar, and other Staff Members for their coöperation in obtaining records used to compile this report.

COMPARISON OF "TOXIC" AND "ATOXIC" CASES

Upon segregating these cases into so-called "toxic" and "atoxic" groups, we were agreeably surprised to find them almost equal in number and that there was no appreciable difference in the average age, the "toxic" being 25 and the "atoxic" 25.2 years. There were 149 toxic, febrile individuals and 151 who had had no fever or appreciable toxic response to their disease, either immediately preceding or throughout their hospital stay. All of the so-called "toxic" cases exhibited some form of acute inflammation, and since MacCallum[5] states that probably every inflammation is accompanied by some general disturbance, such as fever, the presence of an appreciable degree and extent of fever was taken as an index of toxicity existing from the disease present. Cases were therefore arbitrarily placed in a group called "toxic" when fever from the disease of 100° F. or more persisting for two or more days, or of 99.6° F. persisting for four or more days had been experienced. All others were placed in a second group called "atoxic," although we are aware that toxicity may exist without the presence of fever.

Table 1 shows the composition of these two groups, with conditions causing hospitalization and sulfathiazole administration. This study was attempted to identify persons showing evidence of drug intoxication, no thought being given to the existence of proper indications for its administration.

Thirty patients (10 per cent) experienced undesirable reactions from the sulfathiazole, three each exhibiting two different side effects. No deaths attributable to the drug occurred among the entire 300 cases. Table 2 summarizes these side effects as to type and the group in which they occurred.

It is thus apparent that 83 per cent of those patients experiencing undesirable effects were in the so-called "toxic" group, while but 17 per cent were in the so-called "atoxic" group; or expressed in a different manner, 17.4 per cent of the 149 "toxic" patients showed evidence of drug intolerance, while but 3.3 per cent of the 151 "atoxic" exhibited similar effects. Before these figures might be assumed to be significant, it was felt that drug dosage and length of its administration should be compared in the two groups; and upon such comparison it was found that the average "toxic" patient had received 20.5 gm. of sulfathiazole over an average period of 4.9 days. The lowest total dosage was 5 gm. and the highest 71 gm. The shortest time of administration was one day, and the longest 16 days. On the other hand, the average "atoxic" individual had received 25.3 gm. of sulfathiazole over an average period of 7.3 days; the smallest total dose being 5 gm. and the greatest being 101 gm. The shortest period of administration was two days and the longest 35 days.

Thus the average "toxic" patient received 25 per cent less sulfathiazole over a 33⅓ per cent

shorter period of time than did the "atoxic" patient, yet developed five times as many undesirable effects from its use.

ANALYSIS OF PATIENTS EXHIBITING SIDE EFFECTS

This discussion might now have some significance in its relation to the side effects observed in all thirty patients, but definite conclusions cannot be reached without further analysis.

the production of its side effects. We believe that other factors besides dosage and length of administration play a part in their causation. Hendricks[4] appears to confirm this view by his statement that the number and severity of the anemias occurring among his patients given sulfonamide compounds were not dependent upon the total dosage received, the duration of treatment or the blood concentration.

TABLE 1.—*Condition Causing Hospitalization and Sulfathiazole Administration, Placed in "Toxic" or "Atoxic" Groups*

"TOXIC GROUP"*		"ATOXIC GROUP"*	
Upper respiratory infections, acute	34 cases	Gonorrhea	45 cases
Postoperative abdominal	23 cases	Abscess, minor, localized	25 cases
Lobar pneumonia	21 cases	Sinusitis, chronic	15 cases
Bronchitis, acute	20 cases	Otitis media, chronic	15 cases
Broncho-pneumonia	17 cases	Urethritis, nonspecific	13 cases
Cellulitis	9 cases	Prostatitis, chronic	6 cases
Postoperative compound fractures and other operative orthopedic conditions	7 cases	Cystitis, chronic	4 cases
Prostatitis, acute	4 cases	Postoperative compound fractures and other orthopedic cases, operative	4 cases
Epididymitis, acute	4 cases	Balanitis	3 cases
Sinusitis, acute	4 cases	Pustular dermatoses	3 cases
Otitis media, acute	3 cases	Postoperative abdominal	3 cases
Lymphangitis, acute	2 cases	Chancroid	1 case
Infectious mononucleosis	1 case	Entero-colitis	1 case
Encephalitis	1 case	Miscellaneous, used prophylactically, gun-shot wounds, multiple abrasions, lacerations	11 cases
Peri-nephritic abscess	1 case		
Totals	151 cases	Totals	149 cases

* Explanation of terms "Toxic" and "Atoxic" appears in text.

Among these thirty patients, sixteen exhibited side effects sufficiently severe to cause drug discontinuance. These cases are summarized in Table 3, which shows that thirteen (73 per cent) were included in the "toxic" group with but three (27 per cent) being classified as "atoxic." This finding would seem to be not at all inconsistent with the 83 per cent incidence in the otherwise toxic and the 17 per cent incidence in the nontoxic individual as was found in the entire thirty patients experiencing any degree of side effect.

Table 3 also shows that the thirteen "toxic" individuals received sulfathiazole for an average of 5.1 days, as against 9 days for the three "atoxic" patients. Total average dosages for the thirteen "toxic" people was 20.3 gm., as contrasted with an average of 30 gm. for the "atoxic." Again we feel that these calculations are not dissimilar from those found in the entire thirty patients exhibiting side effects.

It is true that Table 3 reveals an average daily dosage of 3.9 gm. of sulfathiazole for the thirteen "toxic" people as against 3.3 gm. for the "atoxic," but it is felt that this difference of less than 1 gm. in the average total daily dosage could hardly account for an incidence of sulfathiazole side effects several times greater in the "toxic" than in the "atoxic" person, particularly since in these sixteen patients the "atoxic" received sulfathiazole on an average of almost four days (80 per cent) longer than did the "toxic." This seems especially pertinent since numerous observers[6] have stated from experimental and clinical observations that prolonged administration of sulfathiazole seems to be a most important factor in

Excessive vomiting seems to occur most frequently early in the course of sulfathiazole administration, and in the cases here cited, this happened in all but one instance. The exception was Case 1 in Table 3. If all early cases of excessive vomiting are excluded from the sixteen cases under discussion, there remain eleven patients, eight in the "toxic" and three in the "atoxic" groups, with a resultant incidence of almost three times the side effects in the "toxic" as in the "atoxic" people. We can find no possible standpoint, but that the incidence of sulfathiazole side effects is much greater in the "toxic" than in the "atoxic" individual. In fact, if we were to eliminate all so-called "'atoxic" cases from our series we would be left with 149 "toxic" individuals with an incidence of 25 patients (16.55 per cent) showing undesirable drug effects, a figure very close to that of Pepper and Ham[3] whose entire series we would classify as "toxic."

DISCUSSION

Clinical findings have been presented from 300 patients given sulfathiazole, in support of a premise that undesirable drug side effects occur more frequently in patients obviously toxic and febrile from their illness, than in those individuals whose disease is unaccompanied by such systemic effects. A review of available literature reveals certain evidence tending to support this contention.

The incidence of sulfathiazole intoxication has been recorded in several series of cases, such as those of Fletcher, Gibson, and Sulkin[3] and Culp,[3] who have reported in the first instance,

women, and in the second, men, treated for gonorrhea, with sulfathiazole. The incidence of drug side effects was 6.7 and 6.9 per cent respectively in those two series. It seems reasonably safe to assume that the majority of the cases in both of these series represented people we would classify as "atoxic." In contrast, others have recorded an incidence of sulfathiazole reaction in groups of cases composed of patients, all or for the most part, of a type classified by us as "toxic." Among these writers are Carrol, Kappel, and Lewis[3] who found a 15 per cent incidence of side effects; Reinhold, Flippin and Schwartz[3] who reported 15.6 per cent occurrences; Volini, Levitt and O'Neil,[3] who recorded 11 per cent; and Pepper and Ham[3] who gave a figure of 18 per cent, and others.[3] Comparison between the findings of the first two and the last six observers would seem to show a higher incidence of sulfathiazole side effects in the person already toxic from his disease.

TABLE 2.—*Type of Side Effects and Group in Which They Occurred*

	"Toxic"	*"Atoxic"*	*Total*
Nausea and vomiting	18	2	20
Fever from drug...	2	3	5
Dermatitis	1	0	1
Dermatitis and drug fever	1	0	1
Agranulocytosis ...	1	0	1
Conjunctivitis, and nausea and vomiting	1	0	1
Cyanosis, and nausea and vomiting	1	0	1
Deaths	0	0	0
Totals	25 (8.35%)*	5 (1.65%)*	30 (10%)†

* Percentages represent incidence in entire 300 cases. Expressed as the incidence among those showing sulfathiazole intoxication they would be 83.5% and 16.5% respectively.

† This table shows thirty patients experiencing a total of thirty-three side effects, two each occurring in three different "toxic" patients.

It is felt that the evident variance in sulfathiazole side effects reported in previously published articles could be explained, at least in part, by the lack of division into "toxic" and "atoxic" cases.

The recent interesting and instructive presentations of Lederer and Rosenblatt,[7] and Merkel and Crawford[8] also deserve comment. Each of these reports cite four deaths apparently attributable to sulfathiazole medication. It was of interest to note that three of the deaths (75 per cent) in the first report occurred in people we would classify as "toxic," while all four patients in the second were apparently toxic from disease although not all were febrile.

If there be any basis of fact for the contention we advance, a reason should be forthcoming. We believe such a reason exists, at least to some extent, in the presence of two factors, in one instance, contributing to the total toxicity of the patient; i.e., drug plus disease toxicity; while in the other but one factor would seem important; i.e., the drug toxicity alone.

To quote MacCallum,[5] further, "when injury is intense enough, poison may be absorbed from the injurious agent or even from dead tissue to affect the nervous system and other organs, and to cause disturbance of their functions and what we know as illness. Even the fever itself may bring along with it disturbances in function." It therefore seems reasonable to say that those patients we have classified as "toxic" had some disturbances in the functions of various organs including the liver and kidneys.

Many observers[9] have pointed out that sulfathiazole is a drug which can and does cause more or less damage in both experimental animals and man, to various organs, including the liver and kidneys; while others[10] have emphasized the importance of proper kidney function during the course of sulfathiazole administration. Reinhold and his coworkers[3] have established that orally administered sulfathiazole in man is excreted up to 93 per cent by the kidneys, a finding supported by the work of Carrol, Kappel and Lewis;[3] while in these same reports the first workers state that transitory depression of kidney function occurs in nearly all patients receiving sulfathiazole, and the second express a belief that fear of accumu-

TABLE 3.—*Patients Exhibiting Severe Sulfathiazole Side Effects, Necessitating Drug Discontinuance*

No. Diagnosis	*Days Drug* Administered*	*Grams of Drug†*	*Reaction Experienced*	*Group*
1. Epididymitis	7	17 gm.	Excessive nausea and vomiting 7th day	"Toxic"
2. Lobar Pneumonia	3	16 gm.	Cyanosis and excessive nausea, vomiting	"Toxic"
3. Lymphadenitis	8	16 gm.	Fever from drug	"Toxic"
4. U.R.I.	2	10 gm.	Excessive nausea and vomiting, early	"Toxic"
5. U.R.I.	2	4 gm.	Excessive nausea and vomiting, early	"Toxic"
6. Broncho-pneumonia	4	22 gm.	Agranulocytosis	"Toxic"
7. U.R.I.	4	15 gm.	Conjunctivitis, nausea and vomiting	"Toxic"
8. Broncho-pneumonia	3	14 gm.	Excessive nausea and vomiting, early	"Toxic"
9. Broncho-pneumonia	10	39 gm.	Dermatitis, and fever from drug	"Toxic"
10. Encephalitis	2	9 gm.	Excessive nausea and vomiting, early	"Toxic"
11. Lobar Pneumonia	12	56 gm.	Fever from drug	"Toxic"
12. P.O. Abdominal	2	9 gm.	Excessive nausea and vomiting, early	"Toxic"
13. Broncho-pneumonia	7	37 gm.	Dermatitis	"Toxic"
14. Localized abscess	9	32 gm.	Fever from drug	"Atoxic"
15. Otitis media, Chr.	10	38 gm.	Fever from drug	"Atoxic"
16. P.O. Orthopedic	8	20 gm.	Fever from drug	"Atoxic"

* Average length of administration: "Toxic" 5.1 days; "Atoxic" 9 days.

† Average total sulfathiazole dosage: "Toxic" 20.3 gm.; "Atoxic" 30 gm.
Average daily sulfathiazole dosage calculated from above: "Toxic" 3.9 gm.; "Atoxic" 3.3 gm.

lation of the drug to dangerous levels is negligible except in those cases showing kidney deficiency, and yet it would appear from the work of Reinhold, et al,[8] that the drug itself contributes, at least to some slight extent, to such deficiency. It thus seems that a vicious cycle affecting kidney function may be established. Fortunately, demonstrable kidney damage was not prominent in our 300 cases, although sulfathiazole crystalluria was demonstrated in 32 per cent of them.

Two years ago, Long, et al[11] stated a belief that kidney disturbances following sulfapyridine or sulfathiazole administration might be due to either a true toxic injury to the tubules of the kidney, probably similar to that seen in mercury bichloride poisoning, or it may be due to the deposition of acetylsulfapyridine or acetylsulfathiazole crystals in the kidney tubules, and on occasion to the blocking of the renal pelves and ureters by calculi composed of acetylsulfapyridine or acetylsulfathiazole.

It now seems apparent that most, if not all, kidney damage from sulfathiazole may be due to crystal deposition in that organ. We are aware of apparently important work now in progress by Sobin,[12] which tends to confirm this view.

Reduction of renal function by both the disease and the drug may conceivably decrease excretion of the drug and thus contribute an additional factor which could contribute to the greater incidence of intoxication in febrile patients.

As a part of this same combination, Martin, and his coworkers,[13] have recently shown that the liver is important in the detoxification of sulfonamide compounds and have presented considerable work in attempting to find a means to assist in the detoxification of those drugs. Considerable evidence[14] is at hand to show that sulfathiazole may have a deleterious effect on that organ resulting in impaired liver function and possible reduction in its detoxicating ability.

No mention has been made in this discussion of side effects occurring from other sulfonamides, since our experience has been restricted almost entirely to sulfathiazole. However, it seems reasonable to assume that other similar drugs might be capable of producing the same phenomena.

SUMMARY AND CONCLUSIONS

The incidence of sulfathiazole side effects in 300 otherwise, young, vigorous soldiers has been cited.

These patients have been divided into a toxic, febrile group, called "toxic," by us for descriptive purposes, and into a second group, nontoxic from their disease, called by us, "atoxic."

The distribution of patients in each group was almost equal in number, with no difference in the average age.

The total incidence of sulfathiazole intoxication in the 300 cases was 10 per cent. There were no deaths attributable to the drug.

Sulfathiazole side effects occurred five times more frequently in the "toxic" group than in the "atoxic," or an incidence of 8.35 per cent for the "toxic," and but 1.65 per cent for the "atoxic."

The hypothesis has been advanced that the combination of effects from disease and drug, affecting sulfathiazole elimination and detoxication can account for the larger number of drug reactions found among the "toxic" patients.

Gross kidney involvement in this series of cases was not evident. No reasons can be advanced for this occurrence, except for excellent nursing care given, and the administration of sufficient fluids during drug therapy.

The occurrence of sulfathiazole side effects reported in other series of cases differ widely. It is suggested that this considerable variance might not exist to such a great extent had previous series been reported as, or had they been divided into "toxic" and "atoxic" cases.

Since we have shown clinically that sulfathiazole intoxication occurs as much as five times more often in the toxic, febrile as in the nontoxic patient, this fact should be kept in mind during the administration of all sulfonamides. This is not to be construed in any sense as an argument against the use of any sulfonamide therapeutically indicated.

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(References Continued on Page 89)

PNEUMOMEDIASTINUM AND SUBCUTANEOUS EMPHYSEMA

FOLLOWING THORACO CERVICAL TRAUMA. RECOVERY FOLLOWING CONSERVATIVE TREATMENT

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PNEUMOMEDIASTINUM is a relatively rare condition. It usually follows upon direct blows to the anterior neck and chest, resulting from rupture of the respiratory tree anywhere along its course from the beginning of the trachea, at the inferior border of the cricoid cartilage, to the alveoli themselves, with the establishment of a communication between the air passages and the anterior mediastinum.

mechanism of production is tearing of the mediastinal reflection of the pleura with escape of air from the pleural space into the mediastinum. In injuries where there results a communication between the trachea or large bronchi and the mediastinum, the mechanism of production is usually by suction of air into the mediastinum by movements of the thorax, as described by Heuer[1] and observed by him in experimental work on dogs. In cases where the lung itself is injured with rupture of the alveoli, air may be forced along the peribronchial and perivascular tissues to the mediastinum, as described by Elki.[2]

But, regardless of the mechanism of production, or location of the comminucation between the air passages and mediastinum, enough positive pressure may accumulate within the mediastinum to compress the vital structures contained therein, so as to greatly embarrass circulation and/or respiration with resultant grave sequelae.

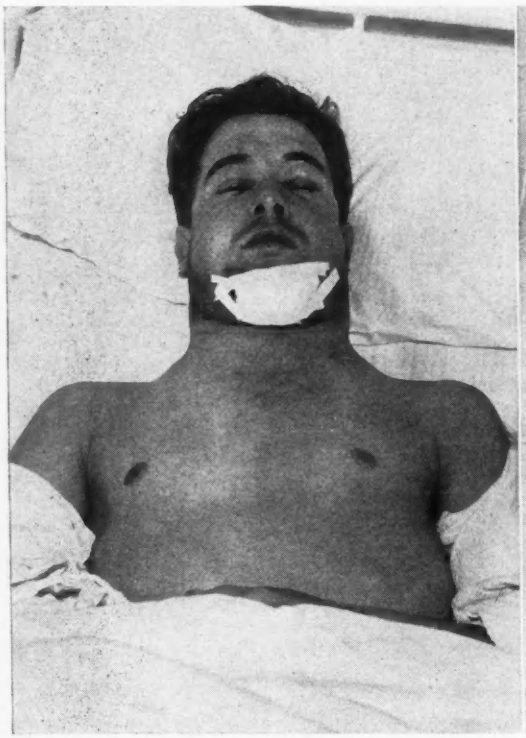

Fig. A.—Photograph showing appearance of patient on October 4, 1942, approximately 36 hours following injury.

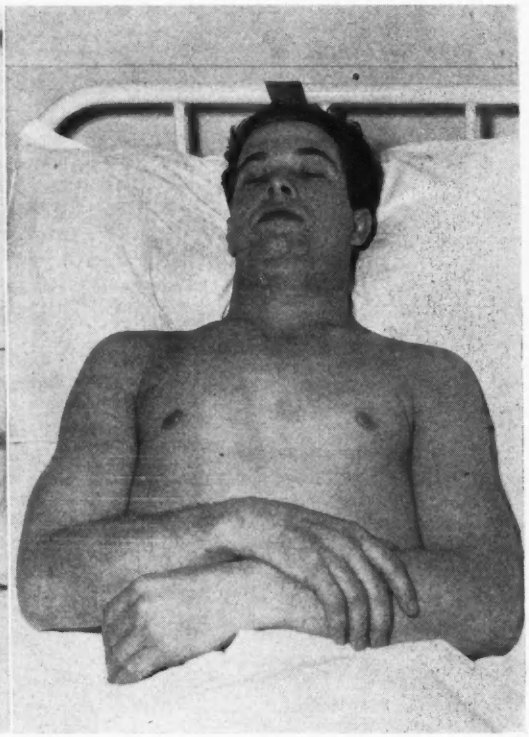

Fig. B.—Photograph showing appearance of patient on October 14, 1942, 2 days prior to discharge.

World conditions, being what they are, offer the opportunity for the more frequent occurrence of trauma to the neck and chest. The management of cases in which pneumomediastinum is a complication of such injuries will no doubt become more standardized as more cases make their appearance and are studied carefully.

The condition is frequently associated with a tension pneumothorax, in which association the

REPORT OF CASE

A 23-year-old adult, white, male, was admitted to the Station Hospital, Fort Ord, California, via stretcher, at 11:50 P.M., October 2, 1942. He presented a severe laceration of the skin of the left chin. There were no other complaints on admission, with no evidence of shock. His past history was essentially negative. His mother had died of tuberculosis in his childhood.

One hour prior to admission he had been in an automobile accident. While riding as a passenger in the front

seat, the car struck another car, throwing the patient headfirst against the dashboard and windshield. He vomited several times after the accident, while lying in the ambulance.

On admission he was not complaining of any pain in chest or neck, and clinically presented only a lacerated chin. He was taken to surgery where the wound was débrided and sutured. Immediately after the soldier was taken off the operating table he began having some dyspnea, with expectoration of blood, and stertorous breathing was noted. Examination revealed a few râles in the right base—no dullness. There was no noticeable swelling of the neck. At this time it was felt he might be developing an aspiration pneumonia. X-ray of the chest taken at this time revealed no definite pneumonia or foreign body in either lung. Nevertheless, at 2:40 A.M., October 3, 1942, he was given the first dose of 2 grams of sulfathiazole, which was continued, grams one, q.4 hours. During the night he was dyspneic, with mild expectoration of bloody sputum, not frothy. There was still no complaint of chest pain.

By morning, October 3, 1942, a definite swelling and emphysema of the soft tissues of the neck were noted clinically. Respirations were 36, pulse 112, and he began complaining of pain in midanterior chest, with severe tenderness over the larynx on slight pressure. There were small areas of ecchymosis of the skin of the neck anteriorly over the central and left portions, and also over the right forehead. During the day the swelling of the neck increased slowly:—respirations remained 36 to 40 per minute, temperature 100, rectally, pulse 120, B.P. 127/78, W.B.C. 17,000 with 65 polymorphonuclears and 35 lymphocytes. X-ray of the chest revealed emphysema of the neck and mediastinum. Fig. 1. No pneumothorax was noted. There was no evidence of fracture of the ribs.

Sulfathiazole was discontinued and sulfadiazine, grams one, q.4 hours, was begun. The patient was placed in an oxygen tent in Fowler's position, in an attempt to reduce the emphysema and dyspnea. There was no cyanosis at any time.

On the following day, October 4, 1942, there was a marked increase in the swelling of the neck, the emphysema extending to the face and upper chest, with skin crepitation to the fifth interspace anteriorly and to the cheeks of the face. Posteriorly, the crepitation was limited to the border of the trapezius muscle on both sides of the neck. The patient's general condition was approximately the same—B.P. 124/80, pulse 96, respirations 28 to 36, temperature 99 F., rectally, W.B.C. 10,000, E.K.G. was normal. His neck measured 18 inches in circumference at its largest point. He complained of pain in the neck on swallowing—cough was brassy and quite distinctive, and seemed to be produced by any slight exertion. There was tenderness over the neck anteriorly, and midsternum. Expectoration was bloody, and very thick and tenacious in character. He was entirely conscious and alert throughout the course of his illness. Ausculation of the chest revealed few râles in the right base, but no dullness. X-ray of the chest revealed pneumonitis (probably aspiration type) in the right base, with increase in superficial and deep cervical emphysema, as well as in the pneumomediastinum. Fig. 2. Auscultatory crepitation over the sternum was present, and on holding of the breath was found to be synchronous with the heartbeat—a pathognomonic sign of mediastinal emphysema (Eloesser's Sign).

On the third day, October 5, 1942, the swelling of the neck and chest was diminishing. The neck measured 17 inches in circumference, respiration 22 and pulse 72. Only complaints were pain on swallowing and hoarseness of voice. The brassy cough and bloody expectoration were present, but diminishing.

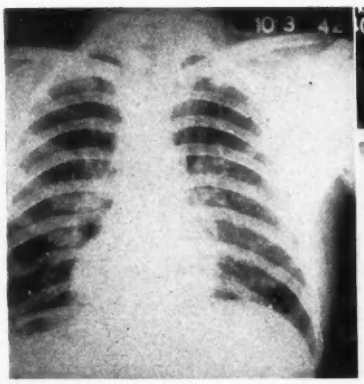

Fig. 1.—Chest taken October 3, 1942, showing moderate amount of cervical emphysema and beginning reflection of mediastinal pleura on right side.

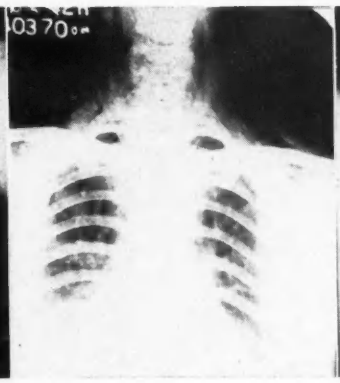

Fig. 2.—Chest taken October 4, 1942, showing increase in amount of cervical emphysema and marked lateral displacement of mediastinal reflection of pleura on both sides. Also showing aspiration pneumonitis, right base.

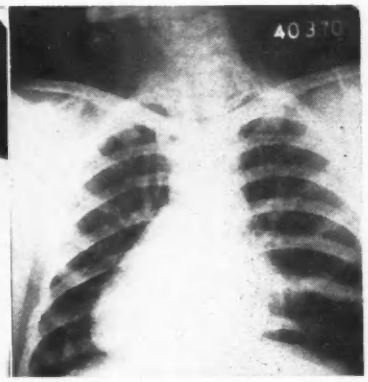

Fig. 3.—Chest taken October 6, 1942, showing some reduction in degree of cervical emphysema but persistence of mediastinal emphysema. Pneumonitis, right base, has cleared.

At 1:00 P.M. the patient was removed from the oxygen tent without embarrassment.

On the fourth day, October 5, 1942, the swelling and emphysema of the neck were greatly diminished. The neck measured 15½ inches in circumference. There continued the brassy cough and bloody expectoration, and hoarseness of the voice. Temperature was 98 8, pulse 76, respirations 22, B.P. 116/70, E.K.G. was again normal. X-ray of chest revealed clearing of the pneumonitis, right base; otherwise there was no change from the findings noted on October 4, 1942. Fig. 3. Improvement thereafter was rapid. All clinical signs of emphysema of the chest and neck had disappeared by October 9, 1942 (or the seventh day of illness). There was no further cough, and only slight hoarseness of the voice. X-ray of the chest at this date revealed marked reduction in the mediastinal emphysema, and emphysema of the deep and superficial tissues of the neck. Fig. 4.

On October 11, 1942, the patient suddenly coughed up three small pieces of fibrous tissue, each about 1 cm. in diameter. These were identified only as fibrous tissue, with no evidence of epithelium or other descriptive type

cervical and facial emphysema, is presented. It is thought that the opening between the air passages and mediastinum was located somewhere along the course of the trachea or larger bronchi, near the bifurcation of the trachea perhaps. Sulfonamide treatment was resorted to early, and the patient was placed in an oxygen tent almost immediately upon the discovery of the condition. The latter two procedures, we believe, are important in the conservative handling of such cases.

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FERTILITY STUDIES IN BARREN MARRIAGES*

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IN the ultimate analysis, production of a child by a couple is the proof that both are fertile. However, the barrenness of a couple does not demonstrate the infertility of both, nor does it show which partner is incapable of procreation.

From the fact that husband or wife, or both, have previously had children it does not necessarily follow that fertility in either one or both is present at the time of examination. So-called "one-child sterility" is quite common; this, of course, is well known. In more than ten per cent of the married folk sent to me, either husband or wife had been a parent before the present marriage; and in approximately five per cent of the cases the couple had had a child several years previously, and during the present marriage.

Up to about ten years ago recognition of male fertility or infertility rested upon a careful history and physical examination, and a cursory semen analysis. If there appeared to be many spermatozoa, and these seemed to be moving about actively, the man was declared fertile and the onus of sterility placed upon the woman. The diagnosis, prognosis and treatment, with possible cure, were then assumed to be solely the responsibility of the gynecologist or obstetrician.

RECENT STUDIES

Scientific study of the semen has progressed greatly during the last decade, owing to the work of Moench, Hotchkiss, Cary, MacComber, and many others. Today there are certain standards that are generally accepted as criteria, within certain broad limitations, as indicative of normal male fertility.

A complete and thorough discussion of the qualifications requisite for normal fertile semen is not within the province of this paper. However, for an understanding of the semen findings in the series reported here, a few generally accepted facts may be stated.

The normal fertile man usually ejaculates from 2.5 to 6.0 c.c. of semen. It is of a creamy color, has a pH of 8.0 to 8.5, a certain viscosity and a distinctive odor. Variation in these characteristics does not necessarily indicate that the individual secreting it is relatively or absolutely infertile. Such deviation or deviations must be weighed in conjunction with other findings in the semen.

Most essential, of course, is a knowledge of the number and other characteristics of the spermatozoa in the semen. The normal fertile male's ejaculation will usually contain from 60 to 300 million spermatozoa per c.c. (Ten per cent must be allowed for possible error.) Of these, at least 50 to 70 per cent remain vigorously active for at least seven hours. Abnormal forms present should not exceed 20 per cent. These differing abnormal forms vary not only numerically in a percentage relative to the whole, but also relative to each other. The tapering form appears to be the one most consistently increased in number in men of lowered fertility. Moench takes 8.5 per cent to be the normal, any increase over this indicating impaired fertility.

A slight change in any of these essentials—number, motility, morphology—does not necessarily imply reduced fertility; but an extreme deviation in any one of them does.

Often, however, an opinion can be formed only after noting how much deviation is present in all characteristics. For instance, if the count of these cells per c.c. is 30-40 million, one would hesitate, on this finding alone, to state that the fertility of the individual was greatly reduced. But, if in connection with this, the motility was found to be diminished to 30 per cent, and there were present 20 per cent of abnormally shaped spermatozoa, one would certainly feel justified in deciding that impaired fertility had been demonstrated.

On the other hand, extreme deviation in any one characteristic—such as an oligospermia in which only an occasional sperm is found in many fields, or semen in which no motile sperm are shown, or the abnormally-shaped cells number 75 per cent of those present—any one of these alone, or similar deficiencies, would warrant a diagnosis of greatly-reduced fertility.

AUTHOR'S SERIES

The series of cases in this report includes only those in which there had been "involuntary" sterility for more than one year; and those in which relatively complete data on both husband and wife were obtained. The wife had been examined by the referring physician and, in his opinion, was adjudged fertile; this examination having demonstrated, of course, the patency of the fallopian tubes.

In determining the husband's causative share

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of cell structure. The sulfadiazine was discontinued at this time, after the patient had received a total of 50 grams, plus 3 grams of sulfathiazole. Atropine, gr. 1/150, q.4 hours was also given the first two days. A total of 4,000 c.c. of 5 per cent gluocose in physiological saline solution were given intravenously for the first three days. Sputum on October 5, 1942, revealed few gram-positive diplococci and numerous short chains of streptococcus. Blood Wassermann was negative. X-ray of the chest, taken on October 16, 1942—date of discharge from hospital—revealed complete clearing of all pathology. Fig. 5.

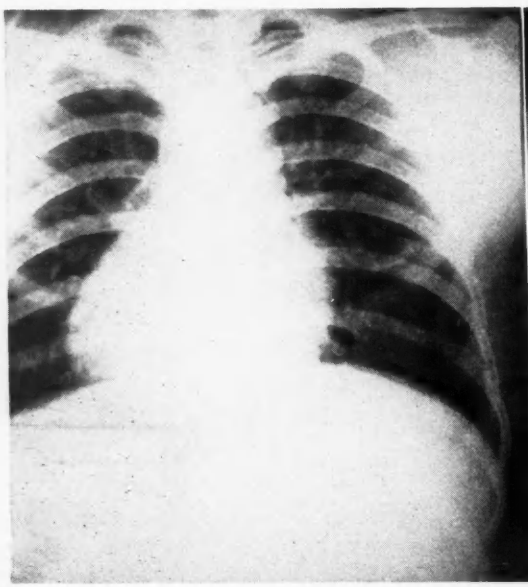

Fig. 4.—Chest taken October 8, 1942, showing marked reduction in degree of mediastinal emphysema.

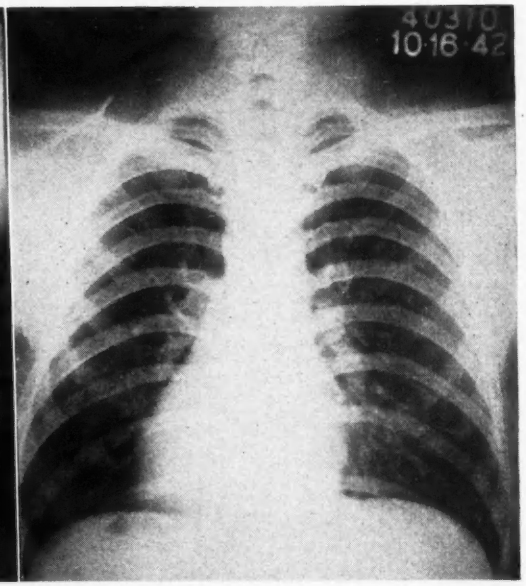

Fig. 5.—Chest taken October 16, 1942, date of discharge, showing complete clearing of both cervical and mediastinal emphysema.

COMMENT

We believe this case to be interesting from at least two standpoints; first, the probable mechanism of production and, secondly, the management.

Although we cannot be sure as to the exact location of the site of the entrance of the air into the mediastinum, we believe that there occurred a rent in the trachea, or one of the larger bronchi some place close to the midline, as the degree of mediastinal pleura reflection was strikingly equal on both sides—as well as the cervical emphysema being distributed almost equally on both sides. Since there was no evidence of pneumothorax or lung tissue injury, the method of production in this case was probably direct entrance of the air into the mediastinum, either by the sucking action produced by respiration or more probably, we believe, by forceful expression of air from the trachea or a larger bronchus into the mediastinum each time the patient coughed, during which act a marked positive pressure would obtain within the trachea with the glottis closed momentarily.

In regard to the management of this case, which we think is the most important feature, heretofore one had to fear the development of mediastinitis with its grave sequela—mediastinal abscess. With the advent of sulfonamides, such fear is less warranted, especially if the sulfonamides be administered immediately upon discovery of the pneumomediastinum, as was done in this case and continued well along until all signs of further ingress of air into the mediastinum have disappeared, or marked reduction in the amount of emphysema has occurred.

Another point in the management is the relief of mechanical pressure upon the venous return of blood to the heart; namely, the superior and inferior vena cavae, as well as upon the heart itself. In cases where there is an associated tension pneumothorax, the treatment of choice is of course aspiration of the air from the pleural space; and in cases without the associated tension pneumothorax, the treatment generally accepted is incision over the suprasternal notch—allowing the air to escape through the opening; but if surgery of the latter sort is resorted to, one must not forget that the danger of mediastinitis is greatly increased.

Surgery was not necessary in our case, even though there was a marked degree of mediastinal air present. We believe that the fact the patient was almost immediately placed in an oxygen tent, thus facilitating the absorption of the nitrogen component from the mediastinal air and tissues of the neck spaces, may have been a factor in the rapid absorption of the emphysema without resort to surgery.

CONCLUSION

An interesting case of mediastinal emphysema with associated marked superficial, and deep

cause of the reduced fertility could not be determined.

In 93 of the whole group of barren marriages it could be definitely stated that the husband was the sole cause; and in 5 instances he was *probably* the cause. However, in 48 cases, or practically one-third of the cases, as judged by our present criteria, both husband and wife were fertile and should have had children born to them during their marriage, yet they were childless.

CONCLUSIONS

It is evident from this study that our knowledge and ability for diagnosing fertility in both male and female is far from complete.

Much of the advance in this field has been made possible by the coöperation between the referring physician, usually a gynecologist or obstetrician, and the urologist.

This association should be developed so that a thorough study is made of both husband and wife in every barren couple. The findings of the gynecologist, obstetrician and urologist may then be pooled, inaugurating proper joint study.

We would have not only more reliable statistics as to the relative responsibility of man and wife, but improved diagnosis and treatment.

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CARCINOMA OF THE PROSTATE: RECENT ADVANCES IN ITS TREATMENT*

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UNTIL recently, the treatment of the metastasized malignant prostate has usually been approached by the attending physician with a feeling of helpless futility. After establishing drainage, and possibly instituting radiation, we had largely exhausted our therapeutic armamentarium. For pain, the increasing frequent need of the narcotic was often not adequate. Mute evidence of this fact is witnessed by the use of various procedures such as cordotomy, sympathectomy, and the alcohol injection of nerves for the relief of pain.[1, 3, 6, 7]

PATHOGENESIS AND TREATMENT

While many have contributed to various attacks on the problem,[4, 8, 17, 14] the recent work of Charles Huggins and his associates[10, 11, 12] has done much to clarify our present knowledge as to the pathogenesis and treatment of this condition. The treatment based on an endocrine aspect is still largely in the experimental phase.

Huggins[12] maintains that carcinoma of the prostate is composed of epithelial cells of a mature type, which are "responsive to depression of the level of androgenic hormone in the organism." By injecting androgen into the system, this activity can be increased. On the other hand, this level can be depressed by the removal of the testes, by inactivating the androgens by estrogen, or by drugs having estrogenic-like effects, such as di-ethyl-stilbestrol.

A number of investigators,[9, 11, 14, 16] studying the relation of carcinoma of the prostate with metastasis, have found the acid phosphatase to be abnormally high in most instances. Huggins has used this as an objective proof in determining the effect of androgen or estrogen in the activity of this enzyme. Thus estrogenic-like substance, such as stilbestrol, when administered, shows marked depression of the serum acid phosphatase level; and when the drug is discontinued, a rise of the acid phosphatase curve is seen. Huggins[13] states dogmatically that "when the acid phosphatase is greatly increased above 10 units, cancer of the prostate with metastatic involvement has always been present, but metastatic involvement may occur without elevation of the serum acid phosphatase. Where the acid phosphatase levels are maintained in certain cases following castration, it is believed to be due to the formation of androgen in extratesticular regions, such as the adrenal cortex and anterior pituitary gland.

"The mechanism by which estrogens reduce the elevated acid phosphatase of serum in carcinoma of the prostate is susceptible of several explanations, which include a direct attack on prostatic epithelium, inactivation of the androgens, depression of the gonadotropic agents of the anterior pituitary, and depression of the interstitial cells of the testes."[13] Castration appears to be the surest way to eliminate the genadal androgens of the testes as a factor. Since androgens may be produced in significant amounts outside the testes, estrogen therapy should also be instituted.

SOURCE MATERIAL

Thirty-one cases of carcinoma of the prostate treated during the past year by castration, estrogens, stilbestrol or a combination of all, are briefly summarized. These patients all complained of some form of pain, varying from minor aches in the back and legs to extreme pains relieved only by opiates. The results obtained seem almost unbelievable—only three cases of this group failing to obtain relief from pain by castration or stilbestrol therapy. Twenty-four of the thirty-one cases were treated by bilateral orchidectomy, the remaining seven being treated by the acid esters of one of the natural estrogenic hormones known as di hydroxy estrin (estradiol di propionate), administered intramuscularly, and di ethyl stilbestrol, an estrogenic-like substance. The latter has the advantage of oral administration and low cost.

All but four patients had some associated urinary retention, which was relieved by transurethral prostatic resections. The pathological report of sections revealed over one-half of these

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in the reported barren marriages, the family history and past history were recorded. In no case was anything found in the family history that appeared to have any significance relative to the patient's infertility.

The results of the physical examination (including indicated laboratory tests), the semen

TABLE 1.—*Causes of Barren Marriages*

		HUSBAND				
		Sole	Probable	Possible	Apparently fertile	
WIFE	Apparently fertile	93			48	141
	Possible		5	4		9
	Probable					0
	Sole					0
		93	5	4	48	150

analysis, together with the patient's history and the marital history, were all taken into consideration in the final determination of the relative responsibility of husband and wife. The results of these findings are given in Table 1.

The husband was classed as being the sole cause of the barren marriage when the examination left no doubt as to his infertility, and the gynecologist or obstetrician had found no pathology in the wife. He was definitely the sole cause in 93 cases and probably the cause of the barrenness in 5. He was classed as the probable cause when his fertility was greatly reduced and his wife showed some very slight pathology.

TABLE 2.—*Male Sterility in 150 Barren Marriages*

Causes		*No. of Cases*
Bilateral Vasectomy		1
Prostatitis		2
Syphilis		2
Testicular Trauma		5
Faulty Development		7
Cryptorchid	4	
Hypogonad.	3	
Mumps Orchitis		8
Gonorrhea		8
Unknown		65
		98

In the four cases in which both husband and wife were placed in the "possible" column, three of the wives had very slightly eroded cervices and the fourth a very small pinpoint os. As those conditions, in themselves, were not considered a sufficient cause, the husband, although his examination indicated fertility, was listed as a possible cause. These four were not included as definitely male infertility cases, although possibly, they should have been included under the "apparently" fertile group.

The 48 couples, in which both man and wife were "apparently" fertile, had been married for periods varying from 1 to 13 years. Twelve out of this group had never attempted to prevent impregnation and in these twelve, as well as the rest of the group, active spermatozoa were found well up in the cervical canal 2 to 4 hours postcoital. The length of time of "involuntary" sterility of these 48 couples varied from 1 to 13 years. Of the 48 apparently fertile couples, two had been married for 13 years. One of these couples had never used contraceptive measures and the other had used them for 12 years previous to the last year of their marriage.

Table 2 shows the causes of reduced fertility in the male, in those cases in which the husband was probably the sole creatively deficient factor in the childless union.

Cases were classified as due to an unknown cause only when the past history, and a careful clinical and laboratory study gave no clue to the etiology.

Prostatitis was not given as a cause except in those cases in which the secretion expressed from the gland was loaded with pus cells, and contained few normal prostatic elements.

Of course a history of gonorrhea alone did not suffice to place this disease in the listing as a cause. Gonorrheal epididymitis accounts for seven of these cases, the eighth being a severe gonorrheal stricture of the posterior urethra which left a distorted and scarred verumontanum with no visible ejaculatory duct openings. It is not improbable that instrumental trauma may have resulted in this obstruction to the ducts.

Syphilis was noted as a causal agent, only because both patients had been told during the acute stage of the disease that the testicles were affected. The testicles of one of them were still very hard and firm, and he had a positive Wassermann reaction. When promptly and efficiently treated, syphilis in the male rarely affects fertility.*

SUMMARY

One hundred and fifty barren marriages have been studied in an attempt to determine to what extent the husband had contributed to, or been responsible for, the childlessness in these marriages. In the opinion of the referring physician the wives were fertile.

Ninety-eight, or 65 per cent, of the men showed definitely reduced fertility. In 65 of these the

* Unpublished Author's Survey.

cases to be a grade III malignancy, and two cases were graded as IV.

Three deaths in this series occurred within a month following castration in practically moribund patients suffering from intractible pain. Subsequent relief from pain was associated with a definite change in mental attitude to one of cheerfulness and grateful appreciation.

Seven patients previously unable to work have improved sufficiently from their pain and disability to permit them to return to their previous activities. Several, which were practically confined to their beds before treatment, have since been able to carry on light work around the yard.

In several cases it was necessary to discontinue stilbestrol administration, due to nausea; but utilizing the enteric coated tablet proved effective in eliminating this factor.

Heavy radiation through the pelvis and testicles was instituted in four cases, a procedure advocated by Counsellor[5] and Munger.[15] The results in these cases have not been as satisfactory or spectacular as that obtained following castration and estrogen therapy.

The dosage of stilbestrol used in this series has been relatively small: 3 mg. daily for the first few days, and subsequent reduction to 1 mg. daily, has been prescribed. If pain tends to persist, the dosage is doubled. A maximum of 18 mg. daily has been used without untoward effect of the drug, in one case.

Comparison of sections of prostatic tissue, from four cases studied by Dr. Albert Brown,[2] Pathologist at the Los Angeles County Hospital, showed "no definite qualitative change in the tumor, except in one case. In this instance the subsequent biopsy revealed advanced necrosis of the tumor, with extreme lymphocytic infiltration. Many of the tumor cells appear to have become syncitial giant cells, with clustered piknotic, distorted nuclei. In general, the quantity of tumor shown in the sections is considerably less than the post therapeutic biopsies. Another change noted is squamous metaplasia principally or entirely confined to the nonneoplastic prostatic glands incidentially present." The following clinical history refers to this case:

REPORT OF CASES

CASE 1.—Initials, C. V. Age 71. Complaint: For years this patient suffered from pains in the hips, ribs and back, which have grown progressively more severe. Three months ago urinary retention developed, and transurethral prostatic resection was done. Pathological examination of the prostatic tissue at that time revealed a grade III adeno carcinoma. The prostate, rectally, was typically malignant. Castration failed to relieve the pains until one week later, when stilbestrol therapy was instituted and his pains disappeared. The patient is now able to enjoy foods which he was unable to eat before, and he is steadily gaining weight. When stilbestrol therapy was instituted, 3 mg. daily was prescribed for the first week. Gynecomastia was noted, and the drug was stopped for two days. However, pains again began to recur and 1 mg. daily was again prescribed. Since that time the patient has felt entirely comfortable and has returned to work. No libido has been noted since the institution of treatment. Microscopic biopsy was taken three months after castration and stilbestrol therapy were instituted.

* * *

CASE 2.—Initials, G. C. Age 61. Patient suffered from symptoms of prostatism, with back and leg pains, for six years. Transurethral prostatic resection done two years earlier was again repeated. Pathological sections revealed a grade III adeno carcinoma of the prostate to be present on both occasions. Castration and stilbestrol therapy were instituted, with prompt subsidence of pain. The prostate by rectal palpation, after three month's treatment, could not be recognized as malignant, although it had been typical of malignancy previously. Clinically, the patient now appears entirely well and is carrying on his normal activity. Biopsy sections of the prostate taken three months later showed no apparent tissue change. He still has a grade III malignancy.

* * *

CASE 3.—Initials, H. S. P. Age 59. This patient complained of severe aching pain in both inguinal regions and across the back, frequency of urination, dysuria, slowness of the urinary stream, and considerable loss of weight during the past six months. There was marked enlargement of the left inguinal node, which was freely movable. The prostate by rectal palpation was enlarged, grade II, hard, irregular and fixed. Two ounces of clear urine were obtained. Transurethral prostatic resection, for palliative relief, was done, and deep x-ray advised. Pathological report revealed adenocarcinoma of the prostate, grade IV. His convalescence was uneventful, but the patient did not feel that he was gaining strength as rapidly as he should. Pain in the hips and legs was relieved by use of barbiturates at first, but finally required opiates for relief. X-ray through the pelvis and groin, and the use of liberal morphine, gave only transient relief from pain. A hard nodule, the size of a walnut, developed in the left inguinal region, and edema of the left leg and lower abdomen was marked. After two weeks of intensive radiation, patient still had little relief of pain, but some indication of diminution of the swelling in the leg was noted. One month later the swelling of the leg again became more marked and began to be noted on the right leg and pubic region. H.M.C.'s No. 1, every 4-5 hours, were taken for pain. The right supraclavicular node became greatly enlarged, and the patient complained of radiating pains across the neck and even across the vertex of the skull. Patient was evidently failing rapidly, but came into the office, by the assistance of his wife and the use of two canes. Bilateral orchidectomy was advised, but patient refused this. He did, however, consent to heavy radiation of the testicles which resulted in some transient improvement. 3 mg. of estradiol dipropionate, three times a week for two weeks, resulted in a marked relief from his pain. The edema was notably diminished in the left leg and the swelling in the sternoclavicular region disappeared. 1 mg. injections, three times a week, for two months were given, and patient discontinued the use of opiates entirely. The last narcotic prescription was written five months ago, and patient now states that he has eight tablets left. Patient is able to do light work around the yard and enjoys surf-fishing. His outlook on life is cheerful, he has put on considerable weight and looks well, and his family is very much encouraged. Examination of the prostatic bed reveals no evidence of hard nodules suggestive of malignancy. The testicles appear atrophic, but patient states libido apparently has been uneffected. Biopsy section of the prostate, taken seven months after instituting estrogenic therapy, failed to reveal any notable changes present in the tissue examined.

Gudeon. Dilford Wilson.

COMMENT

Hope and encouragement can be given to the patient with carcinoma of the prostate. Pain has been relieved in nearly 90 per cent of cases by the utilization of hormonal factors in its treatment. Improvement in appetite and gain in weight have been noted. Actual regression in the size of the gland has been noted after several months' treatment. The disappearance of metastatic nodules in the chest and bones has been demonstrated by some, although none have been noted in this series.

What the future holds for these patients remains yet to be seen. Whatever the ultimate outcome may be, hormonal therapy has offered a grateful respite to many who have already entered the "valley of the shadow of death."

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HYPOTHYROIDISM—LATENT SYMPTOMS*

WILLIAM ANTHONY REILLY, M. D.
San Francisco

DESPITE the present emphasis on early recognition of disease processes and the vogue for preventive medicine, hypothyroidism is rarely detected in its earlier stages and milder forms, and usually not until the most advanced findings have developed. Many text books describe hypothyroidism only in its outspoken manifestations, and imply that all of the classical symptoms should be present—namely, the combination of generalized myxoedema, dwarfism, if it has arisen in childhood, severe osseous retardation, marked hair and skin changes, great somnolence, constipation, retarded mental development, and a very low basal rate.

Ordinarily hypothyroidism occurs as a very mild deficiency, progressing insidiously but persisting permanently. Such cases are far more common than the florid types customarily described. The pathogenesis is mainly governed by the possible interrelationships of the following factors: the age of onset, the degree and tempo of the deficiency, and the response or reactivity of the various body tissues. The degree of deficiency may be progressive or sometimes cyclic, characterized however by exacerbations rather than remissions. Such intensifications are due, as a rule, to intercurrent infections. Usually the tempo is slow and continuous, but may be very rapid as after a thyroidectomy.

Naturally, better therapeutic results will follow if the deficiency can be apprehended in its earlier stages, and before it has been in existence for too great a time. The most important therapeutic desideration, in childhood for instance, is to prevent or improve mental deficiency rather than to be chiefly concerned with the eradication of the disease's physical stigmata.

Very significant is the tissue response to the deficiency. This endocrinopathy can affect all parts of the body. However—and this is important to recognize—not all tissues react equally to lack of thyroid hormone. As a matter of fact, myxoedema is rarely present in the early phases of the disease; not everyone develops anemia; a few will have ascites only, or joint pains only, or thickened tissues about the vocal cords only, or only menorrhagia, as the earliest, and sometimes the only manifestation for a long while in the early period of deficiency. Such partial clinical pictures may remain unchanged for months and even years, or again they may blossom with the further development of classical stigma in other parts of the body, finally flowering into the full-blown text book picture. Such latter cases are in the minority among patients suffering from hypothyroidism.

How, then, is this intangible and early deficit to be recognized? This stage cannot be qualified

*From the University of California, School of Medicine, Division of Pediatrics, San Francisco, California.

by certain "sine quo non" or "must phenomena," so often exactly stated, as for instance, in early diabetes—glycosuria, ketonuria, hyperglycemia, etc. There is hardly one subjective or objective finding, or laboratory test, which either excludes or substantiates the diagnosis of incipient hypothyroidism. Even a profoundly low basal metabolic rate can occur in severe anorexia nervosa, Simmond's disease, Addison's disease, hypogonadism or tubular nephitis, and a normal metabolic reading does not necessarily rule out an early mild deficiency. Moreover repetition of the test may yield a lower percentage. The clinician must rely principally on a critical analysis of the objective and subjective findings, and only secondarily on laboratory aids, and the latter should not be permitted to outweigh or sway his clinical experience, acumen and judgment.

A few terse clinical résumes will perhaps illustrate the diagnostic problem and aid in its solution.

REPORT OF CASES

CASE 1.—A young man of 21 years had a mild deficiency, since his second year; no treatment for the past five years. His features were slightly but definitely myxoedematous, the metabolic rate was 15 per cent minus. Is hypothyroidism to be ruled out because his bone age is between 18 and 20 years, his I. Q. 80 per cent and because there were no other striking complaints or stigmata? Treatment with thyroid extract altered his appearance, improved his vigor, enlivened his personality and drowsiness, cleared his husky voice and eliminated aches in his joints. Properly-controlled thyroid therapy often aids in establishing the diagnosis which prior to the therapeutic test was but a tentative one.

CASE 2.—A 24-year-old lady complained only of stiffness of the knees for some years. She was markedly dwarfed, slightly obese, markedly myxoedematous, her pulse and blood pressure were low, mentality was that of 12 years, bone age of 10 years, basal metabolic rate was 39 per cent minus, and there was a very definite anemia (Hb. 60 per cent, R.B.C. 3,560,000). The transformation during 10 months of thyroid treatment was miraculous. The sole complaint and reason for seeking a physician was stiffness in the knees, yet here were many classical findings slowly developing over many years. The hypothyroidism had originated during early childhood and had been neglected for years.

CASE 3.—Another example of the isolated manifestation is the following: A 51-year-old woman had suffered from attacks of paroxysmal tachycardia for 17 years, and between attacks was found to have a pulse rate of 50 and inverted T waves in all leads. On closer examination she presented many classical clinical signs of adult myxoedema, together with a basal metabolic rate of 31 per cent minus. Under thyroid therapy not only the myxoedema disappeared, but a remarkable improvement occurred also in the cardiac condition which resulted in a transformation of inverted into upright waves in the electrocardiogram. While cardiac myxoedema may not have accounted for her tachycardia, thyroid therapy was responsible for the cardiac improvement.

CASE 4.—Occasionally one has to look long and intently at the facies to detect mild deviations which may have been present for years: A 20-year-old girl, ever since the menarche at 18 years, had had very bothersome menometrorrhagia, yet, on physical examination, outside of a slight puffiness about the eyes and nose, there was nothing to indicate thyroid deficiency. The basal rate was 25 per cent minus. The beneficial response to thyroid therapy corroborated the suspicion of thyroid lack. Left to the natural course of the disease this girl, eventually, over the future years, might have developed far more serious evidence of thyroid failure.

COMMENT

Latent hypothyroidism, accompanied by nervousness, is an odd and almost paradoxical form of deficient function. The nervous cretin, well described in the literature, is a different entity. The former type is sometimes seen in the tall, thin adolescent girls whose basal metabolism is between 10 and 20 per cent minus. Thyroid extract relieves the nervousness, raises the basal rate, is attended by weight gain and a more normal maturity. In some of these cases the thyroid inadequacy may be secondary to a primary hypogonadism.

As Lisser[1,2] phrased it, "Learn ye well the conspicuous peculiarities, capricious vagaries and hidden hints of thyroid failure, and much misery will be spared your patients and much satisfaction added unto you."

SUMMARY

Latent, mild, masked, hypothyroidism is the more common form of deficiency. The course of the disease depends on the age of the onset, degree and tempo of the deficiency, and the tissue response. The classical descriptions of childhood and adult myxoedema, cretinism and of hypothyroidism in general, represent for the most part an outspoken degree of deficiency of long duration. It is possible now as a part of preventive medicine and better therapeutics to pool and closely consider subjective and objective findings, and thus diagnose hypothyroidism earlier in its history.

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Legislative Record of the Seventy-seventh Congress*

The Seventy-seventh Congress adjourned December 16, 1942, after having been in continuous session since January 3, 1941. During this time numerous bills of medical interest, a few of major importance, were considered by the Congress, a large majority of which failed to receive favorable action. In fact, few measures of medical interest passed other than those associated with the general war effort. This should occasion no surprise, for the recent Congress functioned through turbulent times. First the imminence of war and then its actuality necessarily focused sharply the attention of the

* From the A.M.A. Federal Legislative Bulletin, No. 23, J. W. Holloway, Jr., Director.

* For additional news concerning recent legislation, see in this issue, on page 79. For editorial reference, see page 59.

lawmakers on programs pointing to our national security. Other matters received only secondary consideration.

A brief summary of the action taken by the Congress on some of the proposals previously reported in earlier issues of the *Bulletin* follows.

The bill that was introduced to protect diabetic patients from impure insulin became a law. . . .

Proposals were submitted to the Congress to authorize the expenditure of federal funds to investigate the cause of encephalitis lethargica, to provide better facilities for the treatment of cancer and tuberculosis, to authorize the United States Public Health Service to conduct investigations in relation to dental diseases, and to effect a better control of occupational diseases in general and silicosis in particular but none of these bills were enacted. Congress did complete action on the May bill prohibiting prostitution within such reasonable distance of military or naval establishments as the Secretaries of War and Navy may determine to be needful to the efficiency, health, and welfare of the Army and Navy. This measure, of course, has for its objective a reduction in the venereal disease incidence in the armed forces.

Federal funds, to the extent of $5,000,000, were made available for loans to students pursuing accelerated medical courses and certain other designated technical courses. Likewise additional funds were made available to the United States Public Health Service for the training of nurses to augment the supply depleted by the demands of the military program.

Numerous bills were submitted to broaden the field of operation of the Social Security Act. . . . Late in the session Representative Eliot introduced his bill to amend and extend the provisions of the Social Security Act to include, among other things, sickness and hospitalization benefits. While this measure was apparently not officially sponsored, it did undertake to effectuate some of the recommendations submitted by the President in his Budget Message in the early days of the Congress. No action was taken on the bill and it died in the House Committee on Ways and Means.

The Congress took no action on bills to establish a Chiropody Corps in the Medical Corps of the Army and to require the appointment of a chiropodist in each base hospital or training camp. Meeting similar fates were proposals to establish a Pharmacy Corps in the Army. . . . During the early days of the Congress legislation was proposed to open the ranks of the Army Medical Corps to graduates of unapproved medical schools, but no action was taken on it.

Persistent efforts were made by the chiropractors to secure the enactment of the Tolan bill to amend the United States Employees' Compensation Act so as to authorize adherents of this cult to treat beneficiaries of the act, the bill being identical with the measure sponsored by Representative Tolan in the Seventy-sixth Congress. This legislation died on the calendar of the House of Representatives. The osteopaths were likewise persistent in their demands for recognition at the hands of Congress and were successful to the extent that the Surgeon General of the Army was *authorized* to appoint osteopaths as interns in army hospitals and to the extent that *authorization* was included in a bill providing appropriations for the Navy Department for the use of funds "for the pay of commissioned medical officers who are graduates of reputable schools of osteopathy." . . . The authorizations given by the Congress are *permissive* in form only.

While the so-called Wagner-George hospital construction bill received no consideration by the Congress, the Lanham bill became a law by virtue of which considerable federal funds were made available for the construction, in distressed areas, of needed public works, including hospitals, health facilities and clinics. Under this legislation, hospitals, clinics and other health facilities were augmented in many States in areas where existing facilities had proved totally inadequate to serve the influx of population due to defense activities. Additional funds, too, were made available to the Veterans' Administration, $4,557,000 to be exact, for major reconditioning, replacements and new construction of hospitals and domiciliary facilities for veterans. . . .

The President submitted to the Congress a recommendation for such additional appropriations as the Children's Bureau might need during the emergency for allotment to the States for maternal and child welfare purposes. Some of this money, it was contemplated, was to be used in providing medical, hospital, obstetric and pediatric care for the wives and children of men in military service. Companion bills were introduced to effectuate this recommendation but Congress failed to act on them. The Children's Bureau did, however, set aside a part of its regular appropriations for allotments to the States to provide the indicated services for the wives and children of servicemen.

A bill proposing to establish a Federal Department of Health in which could be combined the public health activities carried on by the various branches of the Government failed of enactment. Likewise no action was taken on another bill, sponsored by the Federal Security Agency, to effect a reorganization of the United States Public Health Service.

During the closing days of the Congress legislative action was completed on a Treasury Department initiated measure to regulate the growing of opium poppy in the United States and to provide for the manufacture of opium from the plants. . . .

Another measure enacted during the last days of the Congress increases the pay, allowances and rank of the Army and Navy Nurse Corps and authorizes the employment by the military establishment of and accords a military status to female dietetic and female physical therapy personnel. This law, too, authorizes the employment of other technical and professional female personnel in categories required for duty outside the continental United States.

The Congress took one more step looking toward the provision of adequate housing for the Army Medical Library when it authorized an additional appropriation for the purchase of a site for the building. Apparently, however, this urgent project will not be carried to completion until more settled times.

The new Revenue Act will greatly increase the tax burden of physicians as it will other federal income taxpayers. It does not effect any changes in the deductions that a physician may claim on account of professional activities It does impose an obligation on physicians who have in their employ persons receiving wages in excess of $12 a week a duty of withholding the Victory Tax. The new act eliminates an injustice that has obtained for a number of years in the manner in which outstanding accounts on the books of a taxpayer at the time of his death have been treated for income tax purposes. Hereafter such unpaid accounts will not be considered as part of the income of the decedent for the year of death, as has heretofore been the case, but will be taxable when paid, as a part of the income of the person who receives the money. A provision in the new law authorizes a taxpayer to deduct amounts expended for medical, dental and hospital care to the extent that such expenses exceed 5 per cent of the net income of the taxpayer but not in excess of $2,500 in case of the head of a family, or $1,250 in case of other individual taxpayers.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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† For complete roster of officers, see advertising pages 3, 4, and 6.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

California Procurement and Assignment Service

Following the suggestion made at the January 12-13 meeting of Procurement and Assignment Service in San Francisco by national officers of that service, Dr. Harold A. Fletcher, California State Chairman for Physicians, has appointed a Coördinating Committee for the consideration of problems of medical care in California.

This committee has already held several meetings and is planning weekly sessions, at least for the time being, for the consideration and solution of situations of acute medical shortages which now exist or might come about in California. The first situation under discussion is that in Richmond, where a population of some 90,000 people has grown out of a prewar population of 20,000 and has put a serious strain on the existing medical resources.

Object of the Coördinating Committee is to bring into one group all the resources of agencies with a knowledge of and interest in the field of health service. Washington officials of Procurement and Assignment Service have urged a closer coöperation between these agencies as a means of solving problems which one agency or another might not be able to handle by itself.

Membership of the Coördinating Committee consists of:

Harold A. Fletcher, M. D., Chairman; California State Chairman for Physicians, Procurement and Assignment Service.

W. T. Harrison, M. D., Medical Director, U. S. Public Health Service.

Wilton L. Halverson, M. D., Director, California State Department of Public Health.

Albert E. Larsen, M. D., Medical Director, California Physicians' Service.

Morton Gibbons, Sr., M. D., Medical Director, California State Council of Defense.

L. P. Foard, M. D., Regional Medical Officer, Office of Civilian Defense.

Ernest Sloman, D. D. S., Dental Chairman, 9th Corps Area, Procurement and Assignment Service.

John Leggett, D. D. S., California Chairman for Dentists for Northern California, Procurement and Assign-

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, M.C., at Room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (DRexel 5241).

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. L. C. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone EXbrook 3386, Local 46.

For the southern section of the State, the Office of Naval Officer Procurement is in charge of Lt. Comdr. John P. Ewing, MC. The office is located at the Naval Armory, 850 Lilac Terrace, Los Angeles.

For roster of Procurement Service Committees of County Medical Societies, see July issue of CALIFORNIA AND WESTERN MEDICINE, on pages 93-94.

ment Service.

Karl A. Schaupp, M. D., 9th Corps Area Chairman, Procurement and Assignment Service.

Milton Rose, M. D., Regional Director, Red Cross Unit.

George C. Hahn, D. D. S., President, California State Dental Association.

Anthony J. J. Rourke, M. D., Superintendent, Stanford Hospital.

William P. Shepard, M. D., Metropolitan Life Insurance Co.

Procurement of Medical Officers for the Army in 1943

NOTE.—*The following is an official statement from the Medical Corps of the United States Army indicating the procedure to be followed in procuring medical officers for the Army during 1943.*

The Surgeon General is responsible for the procurement of medical officers for the Army of the United States. There is an Officer Procurement Service set up by the War Department for the procuring of applications of individuals for commission in the Army. The War Manpower Commission has set up a Procurement and Assignment Service for Physicians, Dentists and Veterinarians to designate the individuals who are essential to the community and those available for duty with the armed forces.

In order to coördinate the work of these two agencies, the Surgeon General has outlined the following procedure for the procurement of officers during the year 1943:

The State chairmen of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians will from time to time prepare lists of individuals who are declared available for duty. Their names will be sent to the Central Office of the War Manpower Commission in Washington, D. C. There a card will be prepared and sent to the individual informing him of the fact that he has been classified as available for military service and requesting that he send the attached card to the State chairman of the Procurement and Assignment Service signifying his interest in applying for a commission, and stating his preference for duty with the Army or Navy. Those who choose to serve in the Army may request that their papers be processed with the idea of assigning them to duty with the Air Forces.

The State chairmen will furnish the candidate to the designated field office of the Officer Procurement Service of the War Department. This office will request the individual physician, dentist or veterinarian to complete the proper application blanks and return them to that office and to have a final type physical examinatiton, which will be accomplished at the nearest properly equipped army post.

The Officer Procurement District's office will forward the papers to the Surgeon General in Washington, who will then review the application for commission in the Medical Corps, Army of the United States. Those applications with the notation "Air" as designated will be referred to the Office of the Air Surgeon for further classification and assignment. Those applicants who are favorably considered will be notified at the earliest possible date by the Office of the Adjutant General that their recommendation is accepted and will receive orders to proceed to their proper station.

It is hoped by following this procedure that the Surgeon General will be able to provide an adequate medical service for our armed forces. It is contemplated that all individuals who are classified as essential to the civilian medical needs will not be asked to apply for a commission. No individual so classified need contact the Surgeon General or apply for a commission unless he can make arrangements with the State chairman of the Procurement and Assignment Service to have his classification changed from essential to available. The coöperation and interest of all physicians who are interested in military medical service will be appreciated, in that by proper application and processing of their case it will be much easier to provide necessary medical care for all parts of both the civilian and military services.

Concurrent with the changes in the military and civilian requirements for physicians and the changes in the recruiting procedures, the Surgeon General has announced the following policy, which will govern action to be taken in the consideration of ages and grades of initial appointments on all applicants effective February 15, 1943:

1. Eligible applicants for appointment in the Medical Corps, Army of the United States, under the age of 38 will be appointed in the grade of first lieutenant only.

2. Eligible applicants between the ages of 38 and 55 will be appointed in the numbers and in the grade for which specific position vacancies exist.

There is an acute need for medical officers under 38 years of age. Applications are being solicited from physicians of this age group in those localities that have not furnished their quotas of physicians and where they are designated by the Procurement and Assignment Service as available for military service.

Appointments will be made by the Adjutant General of eligible applicants recommended by the Surgeon General and approved by the Secretary of War's Personnel Board.—*J.A.M.A.*

U. S. Treasury Regulations No. 5: Concerning Prescribing of Narcotics by Physicians in Military Service

State of California
Department of Penology
DIVISION OF NARCOTIC ENFORCEMENT
San Francisco, January 29, 1943.

Dear Doctor Kress:

We have just received a copy of the amendments made to Regulations No. 5, of the U. S. Treasury Department, concerning the prescribing of narcotics by officers of the medical corps of the Army and Navy of the United States.

Since these amendments will be of interest to members of the medical profession, we are enclosing herewith a copy of the amended regulations. Would you please publicize these changes in the next issue of your publication?

With best personal regards, I remain,
Very sincerely,
PAUL E. MADDEN, *Chief,*
Division of Narcotic Enforcement.

* * *

TITLE 26—INTERNAL REVENUE
CHAPTER I—BUREAU OF INTERNAL REVENUE
(T. D. 33)

Part 151—Regulations Under the Internal Revenue Code Relating to Narcotics
(Regulation No. 5)

Importation, Manufacture, Production, Compounding, Sale, Dealing In, Dispensing and Giving Away of Opium or Coca Leaves or any Compound, Manufacture, Salt, Derivative, or Preparation Thereof.

Amendment to Joint Narcotic Regulations Made by the Commissioner of Narcotics and the Commissioner of

Internal Revenue with the Approval of the Secretary of the Treasury.

Section 151.95 of Part 151—(Regulations Under Chapter 23 and 27 of the Internal Revenue Code), Article 95 of Bureau of Narcotics Regulations No. 5, dated June 1, 1938, is hereby amended by adding thereto the following:

Officers of the medical corps of the Army and Navy, in the course of official medical treatment of Army and Navy personnel and members of their families entitled to receive such treatment, are required to issue prescriptions for these patients which may call for narcotic drugs or preparations. Under circumstances where the drug or preparation required by the patient for medical use cannot be furnished from official stocks, it is necessary that it be obtained, pursuant to the official prescription, from a drug store duly qualified by registration under the Federal narcotic law to fill narcotic prescriptions.

Such prescriptions, issued in the course of official professional practice only, and prepared on official blanks or stationery (such as printed forms of an army or navy hospital or dispensary) and otherwise meeting the requirements of Narcotic Regulations No. 5 (Part 151, Chapter I, this Title), relating to narcotic prescriptions, may be filled by a duly registered druggist although they do not bear a registry number of the issuing practitioner; provided they bear the signature, title, corps, and serial or jacket number of the issuing medical officer. Such prescriptions, when filled, shall be filed with, and retained for the same period as narcotic prescriptions issued by regularly registered practitioners and filled by the druggist.

This procedure shall not apply in the case of prescriptions written by an army or navy medical officer in the treatment of a private patient, i.e., a patient not entitled to receive medical treatment from the physician in the latter's capacity as a service medical officer. In prescribing and dispensing narcotic drugs to such private persons, the officer is subject to all the requirements of the Federal narcotic law, including registration and payment of tax, as are imposed upon other physicians conducting private medical practice.

(Signed) H. J. ANSLINGER,
Commissioner of Narcotics.

(Signed) GUY T. HELVERING,
Commissioner of Internal Revenue.

Approved: December 21, 1942.

(Signed) HERBERT E. GASTON,
Acting Secretary of the Treasury.

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48 American Doctors Die in U. S. Service in 1942

Forty-eight U. S. physicians died in military service in 1942, eleven of them in action, the *Journal* of the American Medical Association reported recently.

The *Journal*, in its annual compilation, said there were at least 3,353 deaths of physicians in this country during the year.

The average age at death was 65, as compared with 65.9 in 1941.

"Medical Journal Abstracts" for Physicians in the Armed Forces

In the *Journal American Medical Association*, dated January 23, 1943, a note appears that E. R. Squibb & Sons is distributing to physicians in the armed forces a publication, *Medical Journal Abstracts*. . . .

Medical Journal Abstracts attempts to cover the entire field of medicine and to issue abstracts the *month following date of publication* whenever practicable—the notable exception of course being those periodicals which are printed elsewhere than in the United States. At present more than 165 periodicals are represented and the list is being extended. *Medical Journal Abstracts* is strictly altruistic in its objective and contains no advertising. It is sent only to physicians in the armed services, and is now reaching an appreciable percentage of those in this country and a number overseas.

U. S. Army Will Train Doctors As Specialists

Secretary of War Stimson recently announced a series of special courses whereby several thousand additional army medical and dental officers "will become sufficiently qualified to overcome an acute shortage" in many groups of specialists.

At his press conference, Stimson disclosed the courses will begin January 1st and from 200 to 400 officers will be selected for each class.

"The distribution of professional medical men trained for medical and surgical specialties," he said, "has proved inadequate to meet the demands of war."

However, the secretary added, there are a number of army medical corps officers who could "with a short intensive course, become qualified in a particular specialty, help eliminate the deficit in that specialty."

Stimson said the medical courses for army doctors will be provided at the schools of medicine of the following civilian institutions:

University of Illinois, Northwestern University, Columbia University, University of Pennsylvania, Harvard University, Washington University (St. Louis, Mo.), University of Michigan, Johns Hopkins University, University of California, Stanford University, University of Oregon, Duke University, Lahey Clinic, Boston; Mayo Foundation, Rochester, Minn.; Tulane University, University of Wisconsin, University of Tennessee, University of Chicago, University of Minnesota and Ohio State University.

Military Clippings—Some news items of a military nature from the daily press follow:

10,000 Doctors Will Join Armed Services in 1943

Washington, Jan. 9.—(AP.)—The War Manpower Commission disclosed today 10,000 more of the Nation's 180,000 physicians will be taken by the armed forces in 1943 and said this will leave "more than 80,000" doctors for the civilians.

Chairman Paul V. McNutt promised every effort to provide adequate medical care for civilians, partly through voluntary relocation of doctors to areas of greatest need.

Dr. Frank H. Lahey, chairman of the directing board of the W.M.C.'s procurement and assignment service for physicians, said 80,000 active civilian physicians "is a sufficient number to care for the needs of the civil population if these men and women are properly distributed and allocated and if civilians will take every possible health precaution to keep well."

Doctor Shunning Army Is Ordered Drafted

Chicago, Jan. 9.—(INS.)—Because he did not make application for a commission in the army medical corps, a Chicago physician has been ordered to report to his draft board for induction as a private, it was disclosed today by Lieutenant Colonel E. Mann Hartlett, Illinois selective service medical director.

It is one of the first actions of the kind in the country, Colonel Hartlett said.

The doctor affected by the order had been declared available by the physicians procurement and assignment service last July, but failed to apply for a commission and his draft board was advised to induct him.—*Fresno Bee*, January 9.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Legislative Bulletin No. 1—Public Health League of California

The 55th session of the California Legislature convened at noon on Monday, January 4, 1943. Assemblyman Charles W. Lyon of Los Angeles was elected Speaker of the Assembly and Assemblyman Thomas A. Maloney of San Francisco was elected Speaker Pro Tempore. The Senate elected Senator Jerrold L. Seawell of Roseville as President Pro Tempore. Lieutenant-Governor Frederick F. Houser is president of the Senate.

Predictions are for a short session of the Legislature, as compared with those of recent years, but some of the veterans are wondering if actual adjournment will be reached before the early summer.

Although the general theme is to the effect that only legislation concerned with prosecution of the war effort will be considered, it is to be expected that many of the old issues that have confronted us in the past may be resurrected with an effort to tie them in with the war program. Constant vigilance is necessary.

605 Bills Introduced

As of this date (January 16, 1943), 605 bills have been introduced—213 in the Senate and 392 in the Assembly. No legislation sponsored by ethical medicine or dentistry has been introduced to date. A series of eight bills sponsored by the Association of California Hospitals have been introduced and assigned to committees for hearing when the second session of the Legislature convenes.

Committees

Principal interest to date has been in the make-up of the committees of the two houses. The Assembly has streamlined its organization and there is no longer a Committee on Medical and Dental Laws and a Committtee on Hospitals and Asylums. All committees dealing with health legislation have been combined into the Public Health Committee consisting of 23 members.

Personnel of the committees of particular interest to members of the League follows:

Assembly Committee on Public Health
(23 Members)
(D—Democrat) (R—Republican)

Chairman, Franklin J. Potter (R), Attorney, Hollywood
Vice-Chairman, Ernest E. Debs (D), Tax Statistician, Los Angeles
Edward J. Carey (R), Insurance Broker, Emeryville
Sam L. Collins (R), Attorney, Fullerton
Earl D. Desmond (D), Attorney, Sacramento
Ralph C. Dills (D), Teacher, Compton
C. Don Field (R), Trucking Contractor, Glendale
Edward M. Gaffney (D), Insurance, San Francisco
Chester F. Gannon (R), Attorney, Sacramento
Augustus F. Hawkins (D), Businessman, Los Angeles
John B. Knight (R), Businessman, Los Angeles
Frederick H. Kraft (R), Druggist, San Diego
Jacob M. Leonard (R), Commercial Secy., Hollister
Jack Massion (D), Druggist, Los Angeles
Richard H. McCollister (R), Insurance Broker, Mill Valley
Raup Miller (R), Insurance, Palo Alto
Kathryn T. Niehouse (R), San Diego
Edward F. O'Day (D), Attorney, San Francisco
John B. Pelletier (D), Research, Los Angeles
Lothrop Smith (R), Attorney, Alhambra
John F. Thompson (D), Farmer, San Jose
James E. Thorp (R), Farmer, Lockeford
Frank J. Waters (R), Attorney, Los Angeles

Senate Committee on Business and Professions
(9 Members)

Chairman, John F. Sheeley (D), Labor Executive, San Francisco
Vice-Chairman, H. R. Judah (R), Civic Auditorium Manager, Santa Cruz
Ed Fletcher (R), Land and Water Development, San Diego
James J. McBride (D), Insurance, Ventura
John Harold Swan (D), Junior College Teacher, Sacramento
Hugh M. Burns (D), Funeral Director, Fresno
George J. Hatfield (R), Farmer, Newman
R. R. Cunningham (D), Real Estate, Insurance, Hanford
H. E. Dillinger (D), Merchant, Placerville

Senate Committee on Public Health and Safety
(9 Members)

Chairman, Thomas F. Keating (D), Attorney, San Rafael
Frank L. Gordon (R), Farmer, Suisun
George M. Biggar (R), Farmer, Covelo
Oliver J. Carter (D), Lawyer, Redding
Hugh P. Donnelly (D), Insurance, Turlock
H. E. Dillinger (D), Merchant, Placerville
Hugh M. Burns (D), Funeral Director, Fresno
Chris N. Jespersen (R), Farmer, Atascadero
Randolph Collier (R), Title Business, Yreka

Your League has again established an office in the Hotel Sacramento, where the Executive Secretary, Ben H. Head, can be reached at all times.

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

For address of California Public Health League, see adv. page 5.

California Legislature

55th Session: Report on Bills Introduced
(A—Assembly Bill; S—Senate Bill)

The following is a partial list of proposed statutes introduced prior to the February recess of the California Legislature:

S. 81 and A. 186 propose to amend the sales tax by exempting therefrom the sale of medicines sold as dietary supplements or adjuncts.

A. 6 proposes to amend the osteopathic practice act by eliminating the existing requirement that osteopaths, at the time of the annual renewal of their licenses, present satisfactory evidence of the completion, during the preceding year, of a minimum of thirty hours of professional educational work as approved by the osteopathic board.

A. 44 proposes to amend the Revenue and Taxation Code by exempting from the sales tax medicines or drugs, defined to include any substance or mixture of substances intended to be used internally or externally in the diagnosis, cure, treatment or prevention of diseases of man.

A. 80 proposes to amend the Revenue and Taxation Code so as to include the sales of medicines used as dietary supplements or adjuncts.

A. 129 proposes to amend the Revenue and Taxation Code by exempting from the sales tax the sale of medicines and drugs used in the diagnosis, cure, mitigation, treatment or prevention of disease in man, but not including any instrument or apparatus.

A. 152 proposes the appropriation of $2,000,000 to the regents of the University of California to be expended for the erection and equipment of a hospital to be maintained and supported by the regents in conjunction with the medical school of the University of California.

A. 227 proposes to amend the law relative to the liability of innkeepers so as to include hospitals by providing that a hospital shall be liable for losses of or injuries to personal property belonging to patients to the same degree as would a depositary for hire and providing further that if the hospital keeps a fireproof safe and notifies the patient to that effect then it is not liable for loss or damage to the personal property of a patient except so far as the acts of the hospital contribute thereto.

A. 230 proposes to authorize payments, out of the general funds of a city, city and county, or county, of a physician's fee for issuing a food certificate to any person needing more than the ration thereof might provide.

A. 292 proposes to amend the State labor code by prohibiting an employer or insurance company writing compensation insurance from contracting with any physician,

hospital or other person for the medical or surgical care or hospitalization of any injured person on the basis of such physician, hospital or other person receiving a percentage of the gross premiums collected by such insurance company or on the basis of any percentage of such employer's payroll or on the basis of any fixed charges which are less than the reasonable value of such services as fixed by rates adopted by the industrial accident commission. The bill would further prohibit a physician, hospital or other person from paying over to an employer or insurance carrier any rebate for sums received for the medical or surgical care or hospitalization of any injured employee.

A. 326 proposes to amend the Business and Professions Code relating to the practice of nursing by exempting therefrom the performance of certain services in case of an individual emergency and during a national emergency arising out of war or during an epidemic or other public disaster.

A. 327 proposes to amend the health and safety code regulating the licensing of clinics, dispensaries and maternity hospitals by exempting from such regulation a hospital corporation organized and operated exclusively for charitable purposes.

A. 328 proposes an amendment to the civil code which would create a lien in favor of doctors and hospitals for reasonable charges for hospital care, treatment and maintenance of an injured person, including drugs, supplies and x-ray and laboratory services, on any recovery of any sum had or collected by such injured person whether by judgment or by settlement, not to exceed, however, 50 per cent of such recovery. The proposal then sets forth certain notice requirements which the hospital or physician must give and provides a penalty against any person making payment or settlement of a claim without paying the amount covered by the lien. These provisions would not be applicable to claims arising under the workmen's compensation act, claims for wrongful death or negligent injury to a minor or claims for wrongful death to an adult or minor leaving a husband, wife or children.

A. 329 proposes to amend the law relating to medical and hospital care to indigents by prohibiting the board of supervisors from letting the care, maintenance or attendance of such indigent sick or dependent poor by contract to any person, except that in cases of unusual difficulty or which require treatment or the use of facilities not immediately available in the county and in cases of emergency the board may secure by contract hospital care within or without the county, including medical, surgical, x-ray, laboratory, nursing and general hospital service at a cost not exceeding the fair and reasonable value thereof, in either a private or a State supported institution.

A. 334 proposes to amend the Business and Professions Code relating to the practice of chiropody by redefining chiropody to mean the diagnosis, medical, surgical, mechanical, manipulative and electrical treatment of the human foot and leg. The "and leg" is new and is substituted for the words "including the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the feet."

A. 335 proposes to amend the health and safety code by including a chiropodist in the class of persons who may purchase hypodermic syringes or hypodermic needles or may sign an authorization for such purpose.—*J.A.M.A.*, Vol. 121, No. 5.

California Solons Take Recess Until March 8

Sacramento, Feb. 1.—(INS.)—Legislators today began a 36-day recess, following a 27-day history-making January session of the California Legislature which saw lawmakers enact many emergency measures and grant Governor Earl Warren broad wartime powers.

As the gavel fell on the first part of the fifty-fifth session yesterday and recessing the Legislature until March 8th, legislators had introduced 3,000 bills plus scores of resolutions and proposed constitutional amendments.

Fewer Measures

Although the 3,000 mark was higher than expected, it was still short of the 4,000 bills presented to the Legislature two years ago.

Sandwiched between the regular January session was a special session which enacted the administration's War Powers Act, completely reorganizing civilian defense and creating a 14 member State war council to direct civilian defense activities. . . . —San Francisco *Examiner*, February 2.

Concerning Proposed Amendments to Medical Practice Acts, Permitting Temporary Licensure*

In the January issue of CALIFORNIA AND WESTERN MEDICINE, on pages 2 and 36, appeared comment concerning proposed legislation designed to amend Medical Practice Acts. Of interest, in connection therewith, is the letter which follows, wherein the point of view of the Oklahoma Board of Medical Examiners is expressed.

* * *

(COPY)

OKLAHOMA BOARD OF MEDICAL EXAMINERS
December 19, 1942.

Walter L. Bierring, M. D., Secretary,
Federation of State Medical Boards
of the United States,
406 Sixth Avenue,
Des Moines, Iowa.

Dear Doctor:

This will acknowledge your letter of December 10, 1942, together with enclosures of Proposed Legislation to Authorize and Provide for the Temporary Admission of Practice in this State [Oklahoma] of Physicians and Dentists to Protect the Health of the Civilian Population During the War Emergency Period, also Statement of Principles to be Recommended to the respective State Boards, etc. You are advised that at the regular meeting of the Oklahoma State Board of Medical Examiners, after a full and free discussion of this matter, it was the unanimous opinion of the Board that we are not in accord with findings of the Committee, and do not concur in proposed legislation for the following reasons:

1. We have had some experience with these so-called temporary permits. They are very easy to issue, but very difficult to revoke or terminate, and sometimes easy to transfer.

2. In order to comply with this idea, it would be necessary to completely amend our present laws of Oklahoma, which we think might be extremely dangerous to the profession. Amendments could and would be made not germane to the subject, as amendments would be introduced by radical interest that the Oklahoma State Medical Association has fought for years. We are of the opinion that it would only lower the standards we have been years building up.

3. Oklahoma has no direct reciprocity with any State. Reciprocity is within the discretion of the Board. We reserve the right to reciprocate with those States whose credentials equal or exceed those of Oklahoma, and the Board is sole judge of said credentials.

4. We do not believe it possible to issue a permit to practice in this State and confine the licentiate to a particular area. We have also had experience in this matter.

5. Our board is self-supporting through fees collected from examination, reciprocity, endorsements and annual registration, no legislative appropriation being made. It would, therefore, require a special appropriation by the legislature, which would be necessary to defray expenses of the Board. We feel that the legislature would be unwilling to do this. We would not agree to Section 7 in proposed statement of principles.

6. We do not believe there is an actual shortage of physicians or dentists in Oklahoma, and we know of no one actually suffering due to a supposed shortage of physicians.

7. We do not believe it is just or fair to those already in the service to pass this proposed legislation.

8. The Oklahoma State Board of Medical Examiners has requested that your office furnish us with the names of the members of the Committee of the Federation of State Medical Boards and of the Procurement and

* For editorial reference, see page 58.

Assignment Service present at meeting, as well as the States which they represented, held in Washington, D. C., December 6, 1942.

Yours very truly,
JAMES D. OSBORN, M. D., *Secretary, Oklahoma State Board of Medical Examiners, and*
President of Oklahoma State Medical Association.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Statement by Judge M. C. Sloss, Vice-President, Board of Trustees, Stanford University

Dr. Donald Bertrand Tresidder, a Stanford graduate with the degrees of A. B. and M. D., was elected on January 21, 1943, by the Board of Trustees as president of the University.

Dr. Tresidder was graduated from Stanford in 1919, and from Stanford Medical School in 1927, having been a teaching assistant in anatomy and physiology. He was elected to the Board of Trustees in December, 1939, and as president of the Board in May, 1942. He was the youngest member of the Board. For more than twenty years he has been closely identified with the educational and administrative policies of the University. He is president of the Yosemite Park and Curry Company.

Donald B. Tresidder, M. D.
President-Elect, Stanford University

He succeeds Dr. Ray Lyman Wilbur, who became president of the University January 1, 1916, and since June, 1941, has been its chancellor and acting president. Dr. Wilbur continues as acting president until the end of the present academic year and then as chancellor, to which position he was elected for life tenure.

Search for a new president of the University was undertaken by a joint committee of the trustees and faculty appointed in 1940, and many possibilities were considered. In December, while Dr. Tresidder was in the East interviewing a list of scholars on behalf of the Trustees, the ten heads of the schools, composing the University, prepared and submitted a petition to the Board recommending Dr. Tresidder's election as president. Dr. Tresidder in his contacts with the faculty members had impressed them deeply with his insight into academic problems and his ideals for a university of high degree. Several of the deans were members of an advisory faculty committee which had already reviewed many candidates for the position. After final review and consideration of the entire situation, the members of the Board of Trustees were unanimous in their selection. Dr. Tresidder resigned as a member of the Board since, under the Founding Grant, the president cannot be a member of the Board.

Chancellor Ray Lyman Wilbur, M. D.
Acting President, Stanford University

For the second time in the history of Stanford University, a doctor of medicine has been elected president of the University by action of the Board of Trustees.

He is Dr. Donald Bertrand Tresidder, who, though a qualified M. D., has spent the greater part of his life in the development of Yosemite National Park and in identifying himself closely with the educational and administrative policies of Stanford University. He succeeds Chancellor Ray Lyman Wilbur, also a doctor.

At the age of 49, Dr. Tresidder will reach the peak of a Stanford career which began in 1915 when, as an undergraduate, he worked for his board and room by cooking for a professor of the University.

The head of Stanford will assume his new position on September 1, 1943. He is now president of the Yosemite Park and Curry Company, a position he has held since 1925. He resigned presidency of the Stanford Board of Trustees to accept the university position. Dr. Ray Lyman Wilbur, widely-known president of Stanford University for more than 25 years, reached the retirement age in 1941 when he was appointed chancellor and agreed to serve as acting president until a successor had been chosen.

Dr. Tresidder in his contacts with the faculty members has impressed them deeply with his insight into academic problems and his ideals for a university of superlative quality. In December, the ten heads composing the university prepared and submitted a petition to the Trustees recommending Dr. Tresidder's election as president. Search for a new president was first undertaken in 1940 and many possibilities had been considered.

In accepting the presidency, Dr. Tresidder said:

"The leadership of a distinguished, independent, gift-supported university in these critical times presents both a compelling challenge and heavy responsibilities. I believe implicitly in the future of Stanford as it continues

to serve the living needs of people through education and research, and as it measures up fully to its responsibilities.

"However long the struggle or severe the dislocations arising out of the war, Stanford will maintain a focus where clear, realistic thinking is combined with a fresh, sturdy idealism—where tolerance, respect for the culture of other races and true understanding of the art of living form the cornerstone of a man's education—be he a future scientist, technician, business man or statesman."

Dr. Wilbur Lauds Dr. Tresidder, New President of Stanford

Following election of Dr. Donald B. Tresidder to the presidency of Stanford University, Dr. Ray Lyman Wilbur, acting president, issued the following statement:

"There is an old story about those who sought treasure afar and were surprised upon their return home to find what they were looking for in their own garden. A long search for a new president for Stanford University ends with the selection of one of our most beloved alumni, a Stanford man through and through. Dr. Donald Bertrand Tresidder has a fine mind, a fine spirit, and an appreciation of the true values of higher education. He believes in the privately endowed and privately supported university as of vital importance in our republic.

"Dr. Tressider will go on where some of the rest of us leave off, with the confidence of all and with a sense of public responsibility that will make him an American leader as well as an exceptionally able administrator."—San Francisco *News*, January 22.

COMMITTEE ON SCIENTIFIC WORK

Annual Session—Hotel Biltmore, Los Angeles

Sunday, May 2—Monday, May 3, 1943

CALIFORNIA AND WESTERN MEDICINE, in its January issue, on pages 32-34 presented preliminary information concerning transportation and hotel facilities. The coming, two-day streamlined session received editorial mention in the December number, on page 341. The component county societies have also received communications in regard to the forthcoming session.

Section officers, whose names appear in each issue on adv. page 6, are at work on their respective programs and invite correspondence from prospective essayists.

Members who may question the advisability of an annual session in 1943, should find recent editorial comment in the *New York State Journal of Medicine* to be of interest. Insertion of California for New York, and Los Angeles for Buffalo, would make the remarks equally applicable to the 72nd annual session of the California Medical Association which will close its session on Monday, May 3rd, the day on which New York will hold its first meetings. Quotation follows:

The 1943 Annual Meeting of the Medical Society of the State of New York will be held in Buffalo, May 3-6, 1943, at the Hotel Statler. It will be the second such meeting in wartime and should be attended by all who can possibly be there; yes, and even by those who for some reason think they can't! We know it will be difficult—use of cars restricted, train travel onerous, bicycles rationed, too far to walk, limited hitching and stable facilities for horses, too expensive to fly, canal boats and barges not running on regular schedules. Conditions were worse in grandfather's day, but he came in large numbers, and so will you.

Much has happened since we met in New York last spring, much that you will want to hear about: war medicine and surgery, new treatments, new instruments, changes in methods of practice, what the profession in various parts of the State and elsewhere is doing and planning to meet its particular needs. Invitations to attend have been sent to the membership of the societies of neighboring States so that for the first time this year you will have the opportunity to meet those of our neighbors who can come. In a way, it promises to be rather a regional meeting, for some of the adjacent States have canceled their meetings or planned them at a different time of year or are holding them too far away. So you will see men and women from Pennsylvania, Ohio, Michigan, New Jersey, and possibly even Canada, as well as from the Empire State.

Make your plans now to come. Later we shall tell you more of the scientific program, but just now we ask you to note the dates and to lay your plans to come. Buffalo, May 3-6, 1943—write it down *now* in your engagement book, then watch the *Journal* for further announcements.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Nurses' Pay Raise Sought by Hospitals

Scores of California hospitals are seeking governmental approval of an upward adjustment of staff nurses' salaries in line with standards established by the California State Nurses' Association, officers of the group said yesterday.

Some 90 per cent of the State's hospitals, the officers said, have so far agreed to the increases, which are subject to War Labor Board sanction.

Proposed standards call for a minimum entrance salary of $140 a month, without maintenance, for a graduate nurse, with tenure of service boosts at the rate of $2.50 every six months up to $155 a month.

Hospital applications for Government approval are being sent directly to Dr. Paul A. Dodd,* University of California, at Los Angeles, a member of the N.W.L.B. panel, for combined action. Prompt submission of these voluntary applications was urged.

Organized nursing has advised the hospital group that a health crisis in California, with so many nurses joining the armed forces, could result from delay in adjusting salaries to lure new candidates into the field. It was explained that nurses' salaries have not been advanced in recent years to keep pace with the rising cost of living.—San Francisco *Chronicle*, December 27.

Industrial workers are as much a part of an all-out war effort as are the men in uniform, since twelve men are needed in the factory to keep one man in the field and loss of working time is as serious as the loss of a battle. Tuberculosis is two and a half times as great in industry as in the general population. It thus becomes the serious responsibility of the industrial medical officer to protect such workers by case-finding surveys, and the control of tuberculosis is an important phase of industrial hygiene.—G. J. Wherrett, M. D., *Canadian Pub. Health Jour.*, Sept., 1942.

* Paul A. Dodd, Ph.D. will be remembered as the director who gathered the statistics and later wrote a book dealing with the "Medical-Economic Survey of California."

COMMITTEE ON MEDICAL ECONOMICS

Income Taxes: 1943*

Millions of individuals will be called upon early next year to pay income taxes for the first time. Present taxpayers may find their taxes two to four times the amount paid this year. Few people appreciate how heavy a tax burden has been placed upon the average family budget.

The new wartime rates recently enacted by Congress apply to all of 1942. Ten months of the year have already gone by. This is to urge upon all present and prospective taxpayers the importance of

1. Making plans NOW to meet the heavy taxes payable at the end of this year, and

2. Keeping adequate records from which to compute those taxes. . . .

Beginning January 1, an additional "Victory tax" of 5 per cent will go into effect. Wage and salary earners will have it deducted from their pay checks. It applies to all income over $624 a year plus certain specified deductions. Part of the Victory tax is to be returned after the war, unless the taxpayer chooses to use this post-war credit currently in the purchase of government bonds, payment of life insurance premiums, or retiring indebtedness.

With taxes of this magnitude and complexity, it is imperative that individuals keep records which will enable them to prepare returns and take advantage of all deductions and credits permitted by law. . . .

Under the community property law of California a husband and wife share ownership in the family income on a 50/50 basis, except that from the separate property of one spouse. Because of this split ownership, married couples whose total taxable income exceeds $2,000 may reduce their surtaxes by filing separate returns.

The above is directed primarily to individuals. It is equally important that business concerns inform themselves promptly about the taxes due on 1942 business. New individual tax rates range as high as 88 per cent; corporate normal and surtaxes as high as 40 per cent. The corporate excess profits tax is 90 per cent. The very soundness of a business enterprise may be jeopardized through failure to understand and meet the tax problem.

The Physician's Federal Income Tax—1943

Prepared by the A.M.A. Bureau of Legal Medicine and Legislation

The Revenue Act of 1942 has been correctly described as the greatest revenue raising measure in the history of our country and finds its justification in the tremendous needs of our war program, needs having to do with the actual expenditures for war purposes plus needs in relation to inflation potentialities. The act not only will spiral the tax burden of prior taxpayers but will bring into the income tax picture many millions of persons whose low income has heretofore constituted exempt income. Already plans are under way for additional legislation to raise still more revenue, and the tax burden may reasonably be expected to assume even greater proportions.

During the time when the new act was being formulated by congressional committees and when it was being discussed first in the House and in the Senate, advocates of the so-called Ruml pay-as-you-go plan for the payment of individual income taxes persistently suggested the undesirability of a continuation of the existing practice of taxing during a succeeding year the income received by an individual during a preceding year. There has recently been renewed interest in this plan, and the possibility is not remote that a changed policy may be adopted in the reasonably near future, perhaps by March 15. The President, the Treasury Department and leaders in the Congress have openly espoused the theory of the pay-as-you-go plan, and this espousal has given rise to some doubt on the part of taxpayers concerning the filing of returns this year. The doubt has been apparently so widespread as to call for a public statement by the chairman of the House Committee on Ways and Means, the committee that will initiate any change in our tax procedures, advising taxpayers that a return must be filed on or before March 15 and that that return must be based on the provisions of the 1942 Revenue Act. Despite the uncertainties of the future as to the pay-as-you-go matter, therefore, it is essential that the broad requirements of the new act be fully understood by federal income tax payers.

The Revenue Act of 1942 reduces the personal exemptions of single persons from $750 to $500 and of married persons or heads of families from $1,500 to $1,200. It reduces the credit for dependents from $400 to $350. An additional exemption is allowed members of the armed forces below the grade of commissioned officers. If a serviceman is single, then the first $250 of the service pay he received during 1942 is exempt. If he is married or the head of a family, then the first $300 is exempt. The determination of a taxpayer's status in the armed forces and his family status will be made as of the end of the taxable year for the purpose of this particular exemption.

The basic rate of taxation is increased from 4 per cent to 6 per cent. The surtax rate is elevated from 6 per cent on the first $2,000 of surtax net income to 13 per cent, with a constant increase in rates for incomes in the higher brackets. The earned income credit of 10 per cent remains as heretofore. This credit may be claimed in connection with the normal tax but not with the surtax.

The act continues the provision for a simplified tax schedule for use by taxpayers having gross incomes of $3,000 or less, derived wholly from salaries, wages or other forms of compensation for personal services, dividends, interest, rents, annuities or royalties. The use of the simplified form remains optional. If the taxpayer has no deductions, it will, generally speaking, be to his advantage to use this form. If he has deductions he should tentatively figure the tax under both the regular method and the optional method and use whichever method happens to be to his advantage.

Returns under the new act need not be made under oath, as has been the requirement heretofore. This will relieve taxpayers of the petty annoyance of having their returns sworn to before a notary public or some other official authorized to administer oaths. The taxpayer, however, who falsifies a return will be subject to heavy penalties even though he is not required to execute the return under oath.

Who Must File Returns

In General.—1. Returns must be filed by every unmarried person and by every married person not living with spouse, if fross income during 1942 was $500 or more.

2. Returns must be filed by every married person who lived with spouse, if gross income during 1942 was $1,200 or over. If both husband and wife had income and their combined gross income was $1,200 or over, they must either file separate returns or, if both are citizens or residents of the United States and if they were living together at the end of the taxable year, they may file a

* Bulletin of the Los Angeles Chamber of Commerce.

joint return. If a person was married and lived with spouse for only part of 1942, special rules apply with respect to the filing of returns, and physicians who come within this classification should read carefully the instructions given on the tax return blanks.

If the status of a taxpayer, so far as it affects the personal exemption or credit for dependents, changed during the year, the personal exemption and credit must be apportioned, under rules and regulations prescribed by the Commissioner of Internal Revenue with the approval of the Secretary of the Treasury, in accordance with the number of months before and after such change. For the purpose of such apportionment a fractional part of a month should be disregarded unless it amounts to more than half a month, in which case it is to be considered as a month.

Physicians in Military or Naval Service.—The fact that a physician may be in service does not of itself excuse a failure to file a return, for the income tax act applies to persons in service as well as to persons engaged in civilian activities. Physicians who have gone into service, therefore, should if at all possible, file complete returns before the deadline. While, unfortunately, definite regulations have not been issued to cover the situation, it is understood that, if because of the inaccessibility of necessary records a physician in service is unable to file a complete return, he may file a tentative return on which he must estimate his income, deductions and tax as best he can and indicate on the return his reasons for following this procedure. He will be required at a later date to file a complete return, and necessary adjustments in the tax will be made.

If a physician in service is on duty outside the United States no income tax return or payment of any income tax will become due, generally speaking, until the fifteenth day of the third month following the month in which the physician ceases (except by reason of death or incompetency) to be a member of the military forces on sea duty or in service outside the continental United States, or the fifteenth day of the third month following the month in which the present war is terminated as proclaimed by the President, whichever may be the earlier.

Gross and Net Incomes: What They Are

Gross Income.—A physician's gross income is the total amount of money received by him during the year for professional services, regardless of the time when the services were rendered for which the money was paid, assuming that the return is made on a cash receipts and disbursements basis, plus such money as he has received as profits from investments and speculation and as compensation and profits from other sources.

If a physician receives a salary as compensation for services rendered and in addition thereto living quarters or meals, the value to the physician of the quarters and meals so furnished ordinarily constitutes income subject to tax. If, however, living quarters or meals are furnished for the convenience of the employer, the value thereof need not be computed and added to the compensation otherwise received by the physician. As a general rule, the test of "convenience of the employer" is satisfied if living quarters or meals are furnished to a physician who is required to accept such quarters and meals in order to perform properly his duties. For example, if a physician employed by a hospital is subject to immediate service at any time during the twenty-four hours of the day and therefore cannot obtain quarters or meals elsewhere without material interference with his duties and on that account is required by the hospital to accept the quarters or meals furnished by it, the value thereof need not be included in the gross income of the physician.

Net Income.—Certain professional expenses and the expenses of carrying on any enterprise in which the physician may be engaged for gain may be subtracted as "deductions" from the gross income, to determine the net income on which the tax is to be paid. An "exemption" is allowed, the amount depending on the taxpayer's marital status during the tax year as stated before. These matters are fully covered in the instructions on the tax return blanks.

Earned Income.—In computing the normal tax, but not the surtax, there may be subtracted from net income from all sources an amount equal to 10 per cent of the earned net income, except that the amount so subtracted shall in no case exceed 10 per cent of the net income from all sources. Earned income means professional fees, salaries and wages received as compensation for personal services, as distinguished from receipts from other sources.

The first $3,000 of a physician's net income from all sources may be regarded under the law as earned net income, whether it was or was not in fact earned within the meaning set forth in the preceding paragraph. Net income in excess of $3,000 may not be claimed as earned unless it in fact comes within that category. No physician may claim as earned net income any income in excess of $14,000.

Physicians in Military or Naval Service

As previously pointed out, physicians in service are as much subject to the income tax law as are physicians engaged in civilian practice. The service pay of such physicians must be reported as income. Commutation of quarters and rental value of quarters occupied by medical officers, however, are not taxable income.

If the ability of physicians in service to pay income taxes is materially affected by such service, payment of the tax falling due before or during the service may be deferred for a period extending not more than six months after termination of service. This deferment is authorized by section 513 of the Soldiers' and Sailors' Civil Relief Act of 1940 and applies to all members of the Army, Navy, Marine Corps and Coast Guard, and to all officers of the United States Public Health Service detailed by proper authority for duty either with the Army or Navy, on active duty or undergoing training or education under the supervision of the United States preliminary to induction into service. This does not apply to the tax imposed on employers by section 1400 of the Federal Insurance Contributions Act. This deferment is not automatic. The taxpayer must present evidence to show that his ability to pay the tax is materially impaired by reason of military service. Proof of that impairment should be submitted at the time the tax is due, on a form procurable from the offices of the collectors of internal revenue. A copy of the form was reproduced in the February 28, 1942 issue of the *Journal* on page 737.

The Victory Tax

The physician need give no consideration to the new 5 per cent Victory tax in making his return on or before March 15. As explained in the *Journal*, December 5, 1942, this tax does not apply to income received during 1942, although physicians who are classifiable as employees will periodically have the tax withheld from their salaries during 1943.

Taxation of Accounts Receivable

The Revenue Act of 1942 remedies an unjust method of taxation that has heretofore prevailed in connection with the unpaid accounts on the books of a taxpayer at the time of his death. Under prior law, for the year of death, the value of such accounts has been included as income and subject to the income tax rates, even though

the taxpayer actually received no income at all therefrom. Hereafter the value of the unpaid accounts will not be considered as a part of the income of the decedent for the year of death but will be taxable when paid, as a part of the income of the person receiving the money. A detailed discussion of this matter was published in the *Journal*, January 10, 1942, page 149.

Deductions for Professional Expenses

A physician is entitled to deduct all current expenses necessary in carrying on his practice. The taxpayer should make no claim for the deduction of expenses unless he is prepared to prove the expenditure by competent evidence. So far as practicable, accurate itemized records should be kept of expenses and substantiating evidence should be carefully preserved. The following statement shows what such deductible expenses are and how they are to be computed:

Office Rent.—Office rent is deductible. If a physician rents an office for professional purposes alone, the entire rent may be deducted. If he rents a building or apartment for use as a residence as well as for office purposes, he may deduct a part of the rental fairly proportionate to the amount of space used for professional purposes. If the physician occasionally sees a patient in such dwelling house or apartment, he may not, however, deduct any part of the rent of such house or apartment as professional expense; to entitle him to such a deduction he must have an office there, with regular office hours. If a physician owns the building in which his office is located, he cannot charge himself with "rent" and deduct the amount so charged.

Office Maintenance.—Expenditures for office maintenance, as for heating, lighting, telephone service and the services of attendants are deductible.

Supplies.—Payment for supplies for professional use are deductible. Supplies may be fairly described as articles consumed in the using; for instance, dressings, clinical thermometers, drugs and chemicals. Professional journals may be classified as supplies and the subscription price deducted. Amounts currently expended for books, furniture and professional instruments and equipment, "the useful life of which is short," generally less than one year, may be deducted; but if such articles have a more or less permanent value, their purchase price is a capital expenditure and is not deductible.

Equipment.—Equipment comprises property of a more or less permanent nature. It may ultimately wear out, deteriorate or become obsolete, but it is not in the ordinary sense of the word "consumed in the using."

The cost of equipment such as has been described, for professional use, cannot be deducted as expense in the year acquired. Examples of this class of property are automobiles, office furniture, medical, surgical and laboratory equipment of more or less permanent nature, and instruments and appliances constituting a part of the physician's professional outfit, to be used over a considerable period of time, generally over one year. Books of more or less permanent nature are regarded as equipment and the purchase price is therefore not deductible.

Although the cost of such equipment is not deductible in the year acquired, nevertheless it may be recovered through depreciation deductions taken year by year over its useful life, as described later.

No hard and fast rule can be laid down as to what part of the cost of equipment is deductible each year as depreciation. The amount depends to some extent on the nature of the property and on the extent and character of its use. The length of its useful life should be the primary consideratiton. The most that can be done is to suggest certain average or normal rates of depreciation for each of several classes of articles and to leave to the taxpayer the modification of the suggested rates as the circumstances of his particular case may dictate. As fair, normal or average rates of depreciation, the following have been suggested: automobiles, 25 per cent a year; ordinary medical libraries, x-ray equipment, physical therapy equipment, electrical sterilizers, surgical instruments and diagnostic apparatus, 10 per cent a year; office furniture, 5 per cent a year.

The principle governing the determination of all rates of depreciation is that the total amount claimed by the taxpayer as depreciation during the life of the article, plus the salvage of the article at the end of its useful life, shall not be greater than its purchase price or, if purchased before March, 1913, either its fair market value as of that date or its original cost, whichever may be greater. The physician must in good faith use his best judgment and claim only such allowance for depreciation as the facts justify. The estimate of useful life, on which the rate of depreciation is based, should be carefully considered in his individual case.

Medical Dues.—Dues paid to societies of a strictly professional character are deductible. Dues paid to social organizations, even though their membership is limited to physicians, are personal expenses and not deductible.

Postgraduate Study.—The Commissioner of Internal Revenue holds that the expense of postgraduate study is not deductible.

Traveling Expenses.—Traveling expenses, including amounts paid for transportation, meals and lodging, necessarily incurred in professional visits to patients and in attending medical meetings for a professional purpose, are deductible.

Automobiles.—Payment for an automobile is a payment for permanent equipment and is not deductible. The cost of operation and repair, and loss through depreciation, are deductible. The cost of operation and repair includes the cost of gasoline, oil, tires, insurance, repairs, garage rental (when the garage is not owned by the physician), chauffeurs' wages, and the like.

Deductible loss through depreciation of an automobile is the actual diminution in value resulting from obsolescence and use and from accidental injury against which the physician is not insured. If depreciation is computed on the basis of the average loss during a series of years, the series must extend over the entire estimated life of the car, not merely over the period in which the car is possessed by the present taxpayer.

If an automobile is used for professional and also for personal purposes—as when used by the physician partly for recreation, or so used by his family—only so much of the expense as arises out of the use for professional purposes may be deducted. A physician doing an exclusive office practice and using his car merely to go to and from his office cannot deduct depreciation or operating expenses; he is regarded as using his car for his personal convenience and not as a means of gaining a livelihood. What has been said in respect to automobiles applies with equal force to horses and vehicles and the equipment incident to their use.

Miscellaneous

Contributions to Charitable Organizations.—For detailed information with respect to the deductibility of charitable contributions generally, physicians should consult the official return blank or obtain information from the collectors of internal revenue or from other reliable sources. A physician may not, however, deduct as a charitable contribution the value of services rendered an organization operated for charitable purposes.

Bad Debts.—Physicians who make their returns on a cash receipts and disbursements basis, as most physicians do, cannot claim deductions for bad debts.

Taxes.—Taxes generally, either federal or state, are deductible by the person on whom they are imposed by

law. Both real and personal property taxes are deductible; but so-called taxes, more properly assessments, paid for local benefits, such as street, sidewalk, and other like improvements, imposed because of and measured by some benefit inuring directly to the property against which the assessment is levied, do not constitute an allowable deduction from gross income. Physicians may deduct State gasoline taxes and State sales taxes. In some States sales taxes are imposed on the seller, but, if they are passed on to the buyer, the latter may deduct them.

State income and use taxes are deductible; Federal income taxes are not. Among the Federal taxes that a physician may deduct are those on admissions, dues, initiation fees, safety deposit boxes, tax on telegraph, telephone, cable and radio messages, and the Federal use tax on automobiles. State automobile license fees are deductible. If a State or local fee is imposed for regulatory purposes, and not to raise revenue, the fee may not ordinarily be deducted as a tax. If such fees, however, are classifiable as a business expense, they are deductible as such. Annual registration fees imposed on physicians probably come within the category of regulatory fees and should be deducted as a business expense rather than as taxes. Local and State occupational taxes imposed on physicians are deductible either as taxes or as a business expense, depending on the purpose for which the tax is imposed.

The excise taxes imposed on employers by section 804, title VIII, and section 901, title IX, of the Social Security Act, commonly referred to as old age and unemployment benefit taxes, are deductible annually by employers in computing net income for Federal income tax purposes. If the taxpayer's return is made on a cash basis, as are the returns of practically all physicians, the taxes are deductible for the year in which they are actually paid. If the return is made on an accrual basis, the taxes are deductible for the year in which they accrue, irrespective of when they are actually paid. Employees, including physicians whose employment brings them within that category, may not deduct the tax imposed on them by section 801, title VIII, of the Social Security Act, generally referred to as the old age benefits tax. If, however, the employer assumes payment of the employee's tax and does not withhold the amount of the tax from the employee's wages, the amount of the tax so assumed may be deducted by the employer, not as a tax but as an ordinary business expense.

Medical Expense.—A taxpayer may deduct amounts expended for medical, dental and hospital care, not compensated for by insurance or otherwise, including amounts paid for accident and health insurance, according to a prescribed formula. Deductions will be permitted to the extent that such expenses exceed 5 per cent of the net income of the taxpayer but not in excess of $2 500 in case of the head of a family, or $1,250 in case of other individual taxpayers.

Equipment Necessitated by Military Service.—The cost of equipment of an Army officer to the extent only that it is especially required for his profession and does not merely take the place of articles required in civilian life is deductible. The cost of a uniform is considered a personal expense and hence not deductible.

Laboratory Expenses.—The deductibility of the expenses of establishing and maintaining laboratories is determined by the same principles that determine the deductibility of corresponding professional expenses. Laboratory rental and the expenses of laboratory equipment and supplies and of laboratory assistants are deductible when under corresponding circumstances they would be deductible if they related to a physician's office.

Losses by Fire or Other Causes.—Loss of and damage to a physician's equipment by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair and the cost of repair claimed as a deduction.

Insurance Premiums.—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Under professional equipment is to be included any automobile belonging to the physician and used for strictly professional purposes.

Expense in Defending Malpractice Suits.—Expense incurred in the defense of a suit for malpractice is deductible as a business expense.

Sale of Spectacles.—Oculists who furnish spectacles, etc., may charge as income money received from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should in such cases show charges for services separate and apart from charges for spectacles, etc.

Nontrade or Nonbusiness Expenses

A new provision in the Revenue Act of 1942, permits, in the case of an individual, the deduction of all the ordinary, necessary expenses paid or incurred during the taxable year for the production or collection of income, or for the management, conservation or maintenance of property held for the production of income. While the phraseology of this provision is very broad, the Commissioner of Internal Revenue has by regulation ruled that the following expenses, among others, are not deductible under it: Commuters' expenses; expenses of taking special courses of training; expenses in seeking employment or in placing one's self in a position to begin rendering personal services for compensation; bar examination fees and other expenses incurred in securing admission to the bar, and corresponding fees and expenses incurred by physicians, dentists, accountants and other taxpayers for securing the right to practice their respective professions.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (15)

Alameda County (2)

John A. Blosser, *Oakland*
H. Stewart Kimball, *Oakland*

San Diego County (4)

Laurl W. Moffitt, *San Diego*
Robert J. Prentiss, *San Diego*
Kathleen A. Riffle, *San Diego*
Ira H. Wilson, *Glasgow, Montana*

San Francisco County (8)

J. Prentiss Burtis, *San Francisco*
Thomas Philip Burton, *San Francisco*
John Sampson Chase, *San Francisco*
Richard Henry Creel, *San Francisco*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Gerald M. Feigen, *San Francisco*
Percy A. Millar, *San Francisco*
Meyer L. Mizel, *San Francisco*
Arthur D. Prentice, *San Francisco*

Santa Cruz County (1)

David Maeth, *Santa Cruz*

Transfers (1)

James G. Terry, from San Francisco County to Alameda County

In Memoriam

Beard, Edwin Abraham. Died at Inglewood, January 4, 1943, age 72. Graduate of the College of Physicians and Surgeons, Keokuk, Iowa, 1898. Licensed in California in 1924. Doctor Beard was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Collins, Asa Weston. Died at Redwood City, January 19, 1943, age 67. Graduate of Cooper Medical College, San Francisco, 1903. Licensed in California in 1903. Doctor Collins was a retired member of the San Francisco County Medical Society, and the California Medical Association.

✤

Detling, Frank Edward. Died at Los Angeles, December 25, 1942, age 67. Graduate of Northwestern University Medical School, Chicago, 1901. Licensed in California in 1901. Doctor Detling was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Dillon, Joseph, Jr., Lieutenant (s.g.) Died at sea, December 6, 1942, age 37. Graduate of Columbia University College of Physicians and Surgeons, New York City, 1932. Licensed in California in 1937. Doctor Dillon was a member of the Sacramento Society for Medical Improvement, and the California Medical Association.

✤

Hendricks, Francis Royal. Died at Ventura, December 27, 1942, age 45. Graduate of Jefferson Medical College of Philadelphia, Pennsylvania, 1924. Licensed in California in 1925. Doctor Hendricks was a member of the Ventura County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Kruse, Fred Herman. Died at San Francisco, January 14, 1943, age 64. Graduate of the University of California Medical School, 1915. Licensed in California in 1915. Doctor Kruse was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Noland, Clyde Amandee. Died at Long Beach, October 24, 1942, age 68. Graduate of the State University of Iowa College of Medicine, Iowa City, 1905. Licensed in California in 1929. Doctor Noland was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Owen, Carl Shuey. Died at National City, October 18, 1942, age 65. Graduate of Northwestern University Medical School, Chicago, 1904. Licensed in California in 1906. Doctor Owen was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Quinan, Clarence. Died at Los Gatos, December 8, 1942, age 73. Graduate of Washington University School of Medicine, St. Louis, Missouri, 1897. Licensed in California in 1897. Doctor Quinan was a member of the Placer-Nevada-Sierra County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Rosanoff, Aaron Joshua. Died at Beverly Hills, January 7, 1943, age 64. Graduate of Cornell University Medical College, New York, 1900. Licensed in California in 1922. Doctor Rosanoff was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

✤

Shattinger, Charles. Died at Los Altos, December 13, 1942, age 77. Graduate of Washington University School of Medicine, St. Louis, Missouri, 1886. Licensed in California in 1918. Doctor Shattinger was a retired member of the Santa Clara County Medical Society, and the California Medical Association.

✤

Shattuck, Hobart Parker. Died at Los Angeles, December 10, 1942, age 65. Graduate of Cornell University Medical College, New York, 1903. Licensed in California in 1911. Doctor Shattuck was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Stolle, Francis. Died at Dixon, December 19, 1942, age 54. Graduate of Stanford University School of Medicine, 1913. Licensed in California in 1913. Doctor Stolle was a member of the Solano County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

News Items

On Tuesday, January 12, Mrs. F. G. Lindemulder, State President, met with members, councilors and officers from the 6th and 7th Districts, at a round-table discussion and luncheon, held in the Women's Athletic Club

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

in San Francisco.

In speaking on the rôle of the Medical Auxiliary in war activities, Mrs. Edmond Morrissey, of San Francisco, laid particular emphasis on the Blood Bank. A dramatic interpretation of the History of the Red Cross was given by Mrs. Mary Waterstreet.

Alameda County's January meeting with luncheon was held at the Claremont Country Club. Dr. Robert J. Kerner, Sather Professor of Modern European History, spoke to the group. His topic was "On the Threshold of Victory." The program included a group of songs by Klara Kiefer, accompanied by Helen Berryhill Heilman. Hostesses for the day were Mrs. Roy Nelson and Mrs. Robert Glen.

The first Board meeting of the year was held by the San Francisco Auxiliary on Wednesday, January 5, at the Medical Society's headquarters on Washington Street. A detailed report on the recent Hospitality Day was given. Blood Bank Chairmen, from the various branches conducted by volunteers from the Auxiliary, gave reports.

Miss L. M. Messer, Superintendent of the Kindergarten Division from the State Teachers College, will speak on Nursery Schools at the regular meeting on January 19.

The November meeting of the Woman's Auxiliary to the Sacramento Medical Society was held at the home of Mrs. W. J. Van Den Berg.

During the evening winners in the Annual Public Speaking Contest were presented to the members. This contest is sponsored each year by the Auxiliary, and students from the two high schools of the city and the Junior College are eligible. Subjects of the winners were: "The Possible Dangers of Spreading Disease by Aeroplane," "What Shall We Do to Develop Physical Fitness in Our Youth?" "The Effect of Alcohol Upon Our Armed Forces," and the "Dangers of Self-Medication."

A social meeting was held at the home of Dr. and Mrs. Frederick Scatena on Tuesday evening, December 15, when a program of Christmas music and Christmas carols was enjoyed by the group.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (November)	35,000
Rural Health Program	3,500
War Housing Projects (January 1st) (Approximate)	32,000
Vallejo	10 000
Marin	5.000
Los Angeles	7.000
San Diego	10,000

There have been articles in various magazines and newspapers regarding the C.P.S. plan for medical care for war workers living in Federal Housing Projects. Some of these reports have been accurate, while others contained implications which have caused comment by physicians, laymen, government officials, etc. For the purpose of clarification, it is well to restate, first, C.P.S.'s reasons for entering into the war housing projects, and second, the method by which it operates.

The war housing projects have been constructed in areas surrounding large war industrial plants. These have centered around San Diego, Los Angeles and the San Francisco Bay Area. Large influxes of population have occurred to meet the manpower need of these rapidly growing industries. Many communities have doubled or trebled in population, and during the same period the need of the armed services has reduced the number of doctors available to serve even the original population. Therefore, it is not a question of the ability of the worker to pay for his medical bills, but a question of bringing medical service to him.

In order to do this, it was necessary to increase the doctor power in these areas. Very early it was shown that this could not be done by the voluntary movement of physicians from other locations. Doctors who had active practices in other areas could not afford to move to a new community, where their income would be very uncertain, and even if they were willing to relocate, in most instances they could not become effective immediately. It became evident, then, that there should be available capital to assist physicians to move without causing them financial hardships, and also any such proposal should provide means for making these doctors' skills effective immediately upon relocation. The C.P.S. plan was conceived on the basis of adequately financing this movement, and was only made possible by a working arrangement between the Federal Public Housing Authority and California Physicians' Service. This is where the terms "Built-in medical care" and "Medical care dues with the rent" originated.

Actually, what is transpiring is that the Federal Public Housing Authority acts as the agent of California Physicians' Service in collecting the dues. These dues are set separate from the rent, but are collected at the time a tenant pays his rent. This has simplified the procedure of billing and collecting, which constitutes a large part of overhead cost in other types of prepaid medical care plans.

Also, with the sponsorship and coöperation of the Housing Authority, a larger degree of participation of tenants is acquired, in many instances reaching close to 100 per cent of all of the residents. This puts C.P.S. in a more secure financial position, and will make it possible for us to pay physicians who render extended service on a basis of a higher unit value.

The whole subject of C.P.S.'s entering into war housing projects was carefully discussed and cleared with the Council of the California Medical Association. In each area where these programs are operating, the proposal was again discussed with the local physicians immediately concerned.

Through this C.P.S. plan, physicians who desire to relocate are adding to the community facilities by directly contributing to an essential war effort. The Housing Authority provides the quarters for these health centers in which these C.P.S. physicians may render their services. The physicians in the health center treat the general run of illnesses which occur, and refer the more complicated cases, such as surgery, consultations or cases requiring hospitalization, to professional members of California Physicians' Service who are carrying on private practice in the adjacent communities. In this way, the minor illnesses are handled on the project itself, thus relieving the worker and his family of the inconvenience of travel, and cutting down the loss of working time of

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† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

the worker himself.

Because the minor illnesses are taken care of in the medical center, the overburdened physician in private practice in the community is enabled to serve the normal population more adequately, and has more time available to take care of the severe illnesses which are referred to him from the medical center. This certainly would not be true if the entire responsibility for care of this new population were thrust upon him, with its attendant load of home calls and night calls. Not only is the conservation of the physician's time evident, but the public health aspects of the entire problem are considerably improved. It is perfectly evident that when ten to fifteen thousand people, gathered from all sections of the country, become residents in a compact housing unit, the danger of epidemics is extreme. Because of the availability of the physicians on the project, and the close working relationship of the medical service with the housing authority, these situations can be coped with immediately. Also, by the very availability of physicians and visiting nurses, the amount of disease caught in its early stages (thus preventing more serious complications from developing) contributes to cutting down the morbidity rate of illnesses which could result in loss of manpower.

These are some of the fundamental reasons for C.P.S. entering into this field of medical care, and for the method which has had to be adapted to the conditions.

Farmers' Health Group Will Be Organized Here

Fresno, Kings Ranchers Will Convene to Discuss New Medical Program

Organization of the State Center Farmers' Health Association, to provide a low cost medical program for farm families of Fresno and Kings Counties, will be undertaken at a meeting in the Hotel Fresno, Saturday, January 30th.

The organizing committee is headed by O. M. Davis, master of the Fresno Pomona Grange.

Worked out with the California Physicians' Service, representing 5,300 doctors in the State, the plan is designed to benefit farm families whose net income is $2,000 or less and whose income is at least 50 per cent derived from agriculture. Such families will be eligible for the health insurance at an annual cost ranging from $20 for single adults to a maximum of $60 for a family.

Already In Effect

The plan is being inaugurated here with the assistance of the Federal Security Administration. It is already in effect in many parts of the State.

Edgar H. File, district FSA rural rehabilitation supervisor, said the plan covers not only medical care but hospitalization as well. Persons subscribing to the service may select any physician belonging to the C.P.S., which includes a majority of the doctors in California.

Deadline Is Set

"All prospective members are asked to attend the organization meeting," File said. "The C.P.S. has set February 15th as the deadline for membership in the organization after which no new members will be accepted until February, 1944.

"A president and a board of directors will be elected at the meeting."

Meeting Begins at 8 P.M.

The meeting is scheduled for 8 P.M. Davis will preside. Persons desiring information may contact Davis, through the grange; C. W. Simmons of the Fresno Production Credit Association, or File in Room 302, United States Courthouse and Postoffice, Fresno.—Fresno *Bee*, January 19.

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Vocational Rehabilitation.— S. 2714, introduced by Senator LaFollette of Wisconsin, August 13, and submitted to the Senate Committee on Education and Labor. A bill to provide for the vocational rehabilitation of individuals suffering from war-connected or other disabilities. A companion bill, H. R. 7484, introduced by Representative Barden, North Carolina, August 13, was submitted in the House Committee on Education.

Comment.—This bill is divided into three titles. Title I proposes to enact a War Disabled Vocational Rehabilitation Act. Title II proposes to amend and reënact an act to provide for the promotion of vocational rehabilitation of persons disabled in industry or otherwise and their return to civil employment, approved June 2, 1920, as amended, and to designate that act as the Coöperative Rehabilitation Training Act. Title III proposes the enactment of a Blind Vocational Rehabilitation Act. . . .

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Biltmore, Los Angeles, on Sunday, May 2—Monday, May 3, 1943.

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago, on Monday, June 7, 1943.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a.m., under the title "Your Doctor and You."

In February, KFAC will present these broadcasts on the following Saturdays: February 6, 13, 20, and 27.

The Saturday broadcasts by KECA are given at 10:45 a.m., under the title, "The Road of Health."

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Journals:* How about more subscribing for South American medical periodicals? Get lists from consuls. Note the new XIIth *U. S. Pharmacopeia* (Easton, 1942), gives Spanish synonyms? Remember we're North Americans. Britain's Imperial Chemical Industries publishes interesting general science quarterly with appropriate name *"Endeavor,"* and with big name reviews. Academic Press (125 E. 23rd St., N. Y. C.), issues 2 vols. yearly at $5.50 per, the *Archives of Biochemistry.* Contains intriguing article by W. F. Petersen on Weather and Biochemical Variability (1:269 (Dec.), 1942. How's for seeing that coöperative society journals have broad geographic representation on editorial committees in order to prevent dominance by canons of self-justified ins? *Vale* and let's hope soon *Ave* to Francis Packard and the *Annals of Medical History,* suspending after 25 years! *Federation Proceedings* will be published even though the Federated Societies will not meet—get your abstracts ready! Edwards Bros. of Ann Arbor announce that Vols. 1, 2, and 3 of *Chemical Abstracts* (the hard ones to get to complete your set), will be lithographed and available. Also—the full 59 volumes of *Beilstein's Handbuch der Organischen Chemie* for $400.

2. *Books:* Adam Hilger (98 St. Pancras Way, London, N.W. 1), issues L. Heilmeyer's *Spectrophotometry in Medicine,* and 2nd Ed. of R. A. Morton's *Application of Absorption Spectra to Study of Vitamins, Hormones and CoEnzymes.* Cambridge Instrument Co. (England), issues descriptive pamphlet on the polarograph. G. S. Wilson gives the case for pasteurization of milk (C. Arnold, London, 1942). C. C. Thomas publishes J. Nash's *Surgical Physiology* (Springfield, Ill., 1942). American Council on Public Affairs (2153 Florida Ave., Washington), offers S. Wilsbn's important *Food and Drug Regulation.* Richly significant is J. Needham's *Biochemistry and Morphogenesis* (MacMillan, N. Y., 1942, $12.50). S. P. Lucia's brochure, *The Therapeutic Uses of Wine* (Wine Advisory Board, San Francisco), is good enough to be expanded to a real book. S. Dali's *Autobiography* is as rare an autopsychiatry as W. E. Leonard's *Locomotive God.* Williams & Wilkins (Balt., 1942), offer A. Mueller-Icham's *Internal Medicine in Old Age.* Interscience (N. Y., 1942), issues Vol. 2 of *Advances in Enzymology.* Columbia Press (N. Y., 1942), publishes J. T. Culbertson's *Medical Parasitology.*

3. *Blood:* F. C. Poles and M. Boycott (like J. R. Upton, San Francisco Blood Bank), report on syncope in blood donors (*Lancet,* 2:531, Nov. 7, 1942). K. E. Boorman & Co., like Tom Kelly of San Francisco, discuss clinical significance of RH factor (*Brit. Med. J.,* 2:538, 569, Nov. 7 and 14, 1942).

4. *Biochemorphology:* E. Way urges reading of P. H. Bell and R. O. Roblin's swell note (*J. Am. Chem. Soc.,* 64:2905, 1942), showing bacteriostatic power propor-

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School, Galveston, Texas.

First woman doctor in the 12th Naval District to join the Navy. Dr. Thelma G. Harmon is congratulated by Captain P. K. Gilman, U. S. Navy Medical Corps, while Lieut. Tova Petersen of the WAVES looks on. Commissioned a Lieutenant, junior grade, in the Medical Corps (Women's Reserve), Dr. Harmon has been ordered to the National Naval Medical Center at Bethseda, Md. A graduate of the University of California Medical School with the class of 1931, Dr. Harmon was in practice in San Francisco before joining the Navy.

tional to negativity of SO_2 groups of N^1 substituted sulfonamides. Also W. Alberts remarks on chemophysics of antiseptics (*Lancet*, 2:633, Nov. 28, 1942). H. Burton & Co. discuss bacterial development of colors in contact with sulfonamides as evidence of oxidation factors involved in bacteriostasis. C. B. Allsopp (*Nature*, 150:548, Nov. 7, 1942), reports a water soluble carcinogen derived fr 3:4 benzpyrene. H. J. Robinson and O. E. Graessle (*J. Pharmacol. Exp. Therap.*, 76:316, 1942), give full dope on gramacidin, tyrothricin, and tyrocidin.

5. *Industrial Toxicity:* W. C. Hueper's *Occupational Tumors and Allied Diseases* (C. C. Thomas, Springfield, Ill., 1942), is tops. R. A. Mortensen (*J. Ind. Hyg. Tox.*, 24:285, 1942), shows lead tetraethyl is lung absorbed prop. to conc. about 20 per cent of what reaches alveoli; toxic around 10 mg/kg and rapidly destroyed in tissues. C. D. McCord & Co. (*Ibid.*, p. 265), note that while indium in industry offers no risk, its cmpds. are toxic on parenteral injection—1 to 10 mg/kg, with tissue hemorrhage.

6. *Notes:* S. R. Elek and S. D. Selanz (*Am. Heart J.*, 24:821, 1942), recommend 40 mg papaverine HCl IV as safe repeatable test for circulation time—sudden deep inspiration 16 to 27 sec. in normals, longer in congestive heart trouble, shorter in hyperthyroidism. H. Lehmann & Co. (*Nature*, 150:603, Nov. 21, 1942), show amino acids increase sol. of calcium salts, and kidneys oxidases decrease it. R. E. Johnson & Co. (*J. Nut.*, 24:585, 1942), show need of B complex for men doing hard work.

Doctors at War.—Radio broadcasts of Doctors at War by the American Medical Association in coöperation with the National Broadcasting Company and the medical department of the United States Army and the United States Navy are on the air each Saturday at 2 P.M., Pacific War Time.

Titles, subjects and guest speakers where scheduled for the next five programs are as follows:

January 30. Wake Up America: social hygiene and the war.

Guest speaker, Surgeon General Thomas Parran, United States Public Health Service.

February 6. Rumor Monger: morale in wartime.

February 13. The Heart of a Soldier: strong hearts in the Army.

February 20. "Come and Get It"—the story of how our fighting men are fed.

February 27. "Community Fortress"—health on the home front.

Urge Speedy Naturalization of Alien Physicians.—Because of the acute shortage of civilian physicians throughout the United States, the Immigration and Naturalization Service has been directed to expedite the naturalization of alien physicians, according to a release from the Department of Justice, January 16th. Immigration Commissioner Earl G. Harrison has issued instructions to expedite the filing of petitions for naturalization and to hold hearings in advance of their regular order on the calendar in the cases of practicing alien physicians or aliens who would be qualified to practice if they were citizens. In issuing the instructions, Commissioner Harrison pointed out that many States, either by statute or by the administrative ruling of licensing boards, require applicants to establish American citizenship before they are admitted to the State licensing

examinations for the medical profession. Other States, he said, issue temporary licenses which are subject to cancellation unless citizenship is obtained within a specified period of time. The order expediting naturalization of physicians supplements instructions issued the service in January, 1942, to expedite applications for citizenship submitted by aliens in the armed forces or engaged in national defense work. In the case of physicians they are not required under the new instructions to obtain a letter from a national defense agency testifying to the nature of their employment in order to secure national defense preference in naturalization. Attorney General Francis Biddle emphasized that the new procedure in no way affects the statutory requirements for naturalization but simply expedites the handling of applications.—*J.A.M.A.*, January 30.

U. S. Medical Academy Bill Is Planned.—Washington, Feb. 2.—(UP.)—Senator Elmer Thomas (D., Okla.) said today he plans to introduce a bill calling for establishment of a U. S. Medical Academy, similar to the military and naval training schools for officers at West Point and Annapolis.

Thomas said the school is necessary because "the United States is never going to have a peacetime army of postage stamp size again and any good army must have good doctors and a sufficient supply of them."—San Francisco *Chronicle*, February 2.

Doctors of Medicine as Others See Them.—During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest.

The above item, with some quotations appeared in CALIFORNIA AND WESTERN MEDICINE (July issue, pages 108-109; October, pp. 269-270; November, pp. 287 and 331-332; January, pp. 49 and 50. More recent excerpts follow:

* * *

THE SOUL OF MEDICINE

It has become axiomatic for those who criticize medical men opposed to a fundamental change in the American medical system, to assume that the doctors have a particular ax to grind. As a matter of fact, the doctors have only one concern: the preservation of present high medical standards. As far as financial reward goes, the average doctor could make more money under practically any other system than the present one, which far too often pays him off in nothing more tangible than the satisfaction gained from a job well done; of seeing a sick person made healthy by his skill and experience.

The doctors who today are carrying forward the best traditions of centuries of medical progress simply do not feel bound to kneel before the fancies of social reformers whose only idea of progress is the steady growth of bureaucracy.

For example, they are opposed to compulsory health insurance which is merely a polite word for socialism. Experience in Europe shows that people "protected" by such insurance do not get the medical care now provided by the American system under which the most skilled specialists and surgeons are available to all, regardless of income or economic status.

The following comment of Doctor Edward H. Cary, Chairman of the National Physicians' Committee, on compulsory insurance, expresses the viewpoint of the average doctor—a viewpoint typical of the American medical system in its approach to the whole health problem: "Compulsory insurance introduces the principle of differing qualities of medical care. It would make the doctors mercenary money grabbers and destroy their incentive to greatest efficiency. It would destroy the soul of medicine. It would undoubtedly lower the quality of medical care—and those who would suffer most would be not the doctors but the general public—those who are afflicted with disease."—Chico *Record*, January 5.

* * *

NO TIME FOR HYSTERIA

So far in this war, the doctors have quietly endeavored to comply with military as well as civilian needs. Out of a total of 155,000 medical men in the nation, over forty thousand are giving their skills to the military services. And the heroic job they are doing in faraway corners of the world is well attested to by the recent comment of Admiral Ross T. McIntire, surgeon general of the Navy: "On Guadalcanal scores of doctors and hundreds of the medical corps operate American field hospitals under continuous fire. . . . We have suffered heavy casualties among our medical personnel in these operations." The Marines are no exception. The doctors are everywhere that battles are being fought.

As far as civilian health is concerned, one of the toughest problems is the nurse and the general labor shortage. But the doctors remaining at home are taking steps to alleviate this shortage, even as they are working out a definite program of civilian medical care. All that they need is coöperation on the part of the public. Securing this coöperation is not made easier by the activities of hysterical extremists who would arbitrarily ration doctors like bicycles, with the ultimate aim of socializing medicine.—Sacramento *Shopping News*, December 18.

* * *

DOCTORS LIMITED

"The public believes, and I am afraid we have led them to believe, that we have considerable power in the control of influenza and poliomyelitis, when as a matter of fact the procedures that we now employ in these two diseases are of no demonstrated value.

"In German measles and chickenpox far too much ineffective energy is being wasted for fear the public will interpret our lack of action as willful neglect rather than lack of scientific knowledge. In the case of whooping cough more facts are needed before we can serve a very helpful purpose."

That very frank statement about American medicine was made by Dr. John L. Rice, commissioner of health, New York City, and quoted in a recent issue of the weekly bulletin of the California Department of Public Health.

Dr. Rice's admission that doctors are neither omnipotent nor infallible may come as a rude shock to some persons who far too often are prone to blame the physician when a friend or relative fails to respond to treatment, but in this flat statement of facts the New Yorker is not attempting to alibi for his profession but merely pointing out that he and his colleagues have certain limitations just as do the persons of any other profession.

Science has made great steps in combating various diseases, but there still is much to be learned, as Dr. Rice points out, and the public should bear with the men of medicine who are doing their best with the tools and knowledge they have at hand. The public should understand that failure to prevent or cure certain maladies does not necessarily mean willful neglect but usually means that the methods of combating the diseases have

not yet been discovered.—Sacramento *Union*, December 25.

* * *

Good Health Is a Duty

Do you remember the virulent flu epidemic of 1918? When twenty million Americans were stricken?

Of these, six hundred thousand died—more than ten times the American death losses in action in the entire first World War, more than two and a half times the total of American war casualties, killed and wounded!

So far no epidemic has struck America in this war. Perhaps none will—and this is devoutly to be hoped. But diseases from malnutrition and exposure and cold are rising throughout Europe, according to news dispatches; and one of war's necessities is that ships that might carry contagion cross and recross the oceans between America and all parts of the world.

Thousands of doctors are joining the colors to care for the fighting men; and medical authorities are predicting that rationing of doctors for the civilian population is in the offing.

Such facts present to every citizen his duty to maintain his health and strength by observing common sense rules of living. A sick citizen is a loss of manpower for the war effort. A sick citizen may be a danger as a focal point for the spread of sickness to others. A man cannot help getting wet feet—but he takes needless risk by neglecting to change to dry socks and shoes as soon as he gets home. A man with a feverish cold and cough has no right, in these times, to go to shows or other crowded places where he may infect others.

Every individual and family may help greatly in holding the scourge of sickness to that irreducible minimum by eating plenty of nourishing food and taking adequate rest, by avoiding undue exposure and fatigue, by spending as many hours as possible in the open air and sunshine, and by giving attention to minor, incipient ailments as soon as they appear.

Good health has always been a priceless personal reward of common sense living. Today, good health is a wartime duty.—Hanford *Journal*, December 19.

* * *

Do Your Part to Help the Doctor

The individual citizen can help relieve the wartime medical problem. Here are suggestions:

Choose your physician carefully and stick to him. Make appointments for visits as early as possible. Whenever advisable visit the physician's office instead of expecting him to call at your home. Write down all important facts you want to tell him. Tell him all symptoms which have any bearing on your physical welfare. Have confidence in him. Write down his orders and make sure you understand them.

Public coöperation can go far toward eliminating the "doctor shortage."—No. Sacramento *Journal*, January 15.

Smallpox in Los Angeles County.—The recent report by the Los Angeles County Health Department of a probable case of smallpox in the city of Torrance emphasizes again to the citizens of Los Angeles that this disease does exist. Although no cases have been reported for approximately four years in the city of Los Angeles, vigilant efforts must be made to prevent its recurrence.

It is important to note that for the week ending January 2, 1943, there were 5 cases reported from Indiana, 34 cases from Pennsylvania, and 7 cases from Texas. The possibility of the introduction of smallpox to the city of Los Angeles, therefore, is far from remote. It is constructive to note the effects in the city of Los Angeles of an intensive program of vaccination against smallpox in the city schools, which was begun in 1932. From 1924 through 1933, inclusive, there was an average of 682 smallpox cases per year; from 1934 to 1939, an average of 64 cases per year; and since 1939 there have been no cases reported.

It is only by the reduction of susceptibles by a continued campaign of vaccination that this dreaded disease can be eliminated.

California Historical Society.—At its meeting of January 28th, held in San Francisco, the California Historical Society elected George D. Lyman, M. D., San Francisco, President for the ensuing year. Morton R. Gibbons, M. D., San Francisco, was elected a member of the Board of Directors.

The California Historical Society publishes an illustrated quarterly containing original and authoritative articles embodying much research; publishes pamphlets and books on Western history; maintains a museum and gallery of prints and other early illustrative matter; possesses an extensive library, and holds monthly luncheon meetings at which speakers discuss interesting subjects pertaining to Western history.

Campaign to Save Hearing.—The Bulletin of the Southern California Breakfast Club—a Coördinating Council for the Hard of Hearing Societies of Southern California—and functioning as Chapter 124 of American Society for the Hard of Hearing, in its January issue, contained the following paragraphs:

"The eighteen chapters constituting the Southern California Breakfast Club and all the other Societies for the Hard of Hearing in California urge attention to this age-old problem of hearing impairment:

"Modern science and treatment have got Poor Ears licked for at least one-half of the victims. That is what the otologists and scientists tell us. But the parents don't know that yet. Modern, up-to-date testing of hearing is yet in its swaddling clothes. It is new, but is not untried. Things move so swiftly these days. It is hard to keep up.

"Please keep the two words 'Save Hearing' in mind. California should have a well-planned health program for conservation of hearing. It does not have one. . . .

"The DEAF are those in whom the sense of hearing is nonfunctional for the ordinary purposes of life. There are very few DEAF persons in our State. A well-equipped and administered School for the Deaf is provided for them at Berkeley. There are about 350 deaf children in residence there. Others are being given full education in special schools in our largest cities.

"The HARD-OF-HEARING are those in whom the sense of hearing, although impaired, is functional with or without the use of a hearing-aid. They have defective hearing but are not deaf. They should never be called DEAF. There are between 10 and 15 thousand children in California who have seriously impaired hearing. Many times that number have slight hearing loss which may develop later, unless corrected in time, into a handicapping loss."

Research on Alcohol: Award of $1.000.—The Research Council on Problems of Alcohol announces a $1.000 award, for an outstanding research on alcoholism during 1943:

1. The research for which the award will be granted must contribute new knowledge, in some branch of medicine, biology, or sociology, important to the understanding or prevention or treatment of alcoholism.

2. Any scientist in the United States, Canada or Latin America is eligible for the award.

3. The project may have been inaugurated at any time in the past or during the year 1943, provided (a) that a substantial part of the work be carried on during the year 1943, (b) that it be developed to a point at which significant conclusions are possible before the end of the year, and (c) that a report on the work has not been previously announced and described before a scientific body or previously published.

4. It is desirable, but not necessary, that those planning to work for the award send to the Council before March 1, 1943, a statement of such intention. If the Council receives such information, it can be helpful in the prevention of undesirable duplication of effort. If a research project is conceived and inaugurated later in the year, 1943, a statement of intention may be sent to the Council at a later date.

5. A report on the work and resulting conclusions must be submitted to the Research Council on Problems of Alcohol on or before February 15, 1944. The Council will provide an outline for use in the preparation of reports.

6. The award will be in cash, and will be given to an individual scientist whose work is judged sufficiently outstanding and significant to merit the award.

7. The Committee of Award will consist of five persons—an officer of the American Association for the Advancement of Science, and four representatives of the Scientific Committee of the Research Council on Problems of Alcohol.

8. If the Committee is not convinced of the outstanding merit of the research done during 1943 as described in reports submitted, it may, at its discretion, postpone the award until another year, or until such time as work of such merit has been performed.

The Council will send on request, to any scientist, an outline of basic policies governing its research program, lists of Council studies (completed, under way and contemplated), and information regarding the studies of other agencies.

Scientists planning to do research in connection with the award may send a statement of intention to the Director, the Research Council on Problems of Alcohol, Pondfield Road West, Bronxville, New York.

Social Hygiene Takes Battle Stations.—Social Hygiene Day, sponsored annually by the American Social Hygiene Association, 1790 Broadway, New York, was observed on February 3, 1943. Communities throughout the United States and its territories held local meetings where the American public gathered to discuss the problem of venereal disease control during the war. Stressing the urgent wartime need for a vigorous offensive against the venereal diseases, the Association's theme for the 1943 campaign was "Social Hygiene Takes Battle Stations."

Infantile Paralysis: Grants to California Schools.—In a recent bulletin, the National Foundation for Infantile Paralysis calls attention to the general expansion and intensification of the nation-wide fight against infantile paralysis, with progress made in scientific attacks on the crippling disease. . . .

The included financial statement reveals 77 grants and appropriations totaling $1,142,009.35 for the fiscal year ended September 30, 1942. The money was disbursed to medical schools, hospitals, research laboratories, health institutes and foundations, from funds raised by the "March of Dimes" and Celebrations of President Roosevelt's Birthday. . . .

For virus research the National Foundation made 23 grants to 21 institutions for a total of $543,749.46. Of the grants seven were to men or institutions whose work had not previously been supported by the Foundation.

Among the grants were: George Williams Hooper Foundation of the University of California, San Francisco, $21,526; Stanford University School of Medicine, San Francisco, $10,035; University of Southern California School of Medicine, Los Angeles, $10,000. . . .

For educational purposes there were three appropriations and 12 grants to 10 institutions in 7 States, the total amount being $227,540.80. Principal grants were: Stanford University School of Health (Women), Palo Alto, California, $9,520. . . .

World War I: Syphilis Cases.—During the first World War there were 157,146 more new cases of syphilis and gonorrhea among United States soldiers, sailors, and marines than there were wounds in battle itself. Total absences from duty due to this cause kept the equivalent of 20,600 men out of the fighting for a whole year. The loss in terms of today's hardheld fronts: twenty thousand men would man five huge aircraft carriers and nine destroyers.

Rationing of Canned Milk Unnecessary: Temporary Shortages Due to Hoarding, Say Manufacturers.—Housewives who have had to shop from store to store to get sufficient evaporated milk for the baby's formula can take comfort from the statement of Dr. Frank E. Rice, Executive Secretary of the Evaporated Milk Association, that shortages of canned milk are being relieved rapidly. Manufacturers of evaporated milk from all parts of the country, meeting in Chicago recently, report that production is on the increase, normal supplies are being released to the trade, and grocers' shelves will be additionally replenished from the huge stocks of evaporated milk held by the government. . . .

"The recent announcement that O.P.A. had been granted authority by Secretary Wickard to ration evaporated milk is most unfortunate, coming at this time," said Doctor Rice, "since it will only aggravate hoarding and prolong the temporary shortage. The capacity of the industry to produce evaporated milk is ample to take care of all requirements which can be foreseen at this time for 1943."

Kenny Method in Infantile Paralysis.—In an open letter to all Chapters, the National Foundation for Infantile Paralysis makes the following statements:

It is vitally important that all Chapters of the National Foundation, and all hospitals admitting infantile paralysis patients, know what the Kenny method is and who can apply it.

The Kenny method is not a "cure" for infantile paralysis. It *is* the most satisfactory method yet developed for *treating* early cases; it is not designed for treatment of long-standing cases. The earlier the treatment is provided the better it will be for the patient. The treatment should start the day the diagnosis is made. Every day's delay may add weeks to the period of hospitalization. Cases can be treated after several weeks', or even months' delay, but the results may not be so good. Certainly the treatment will be prolonged, causing unnecessary expense and misery.

The Kenny method of treatment is based not upon the older concept of the symptoms but rather upon a new idea advanced by Miss Kenny. This idea has been put to many tests and has been found so far to be sound and based on well recognized principles of pathology and physiology. The method is neither easy to understand nor easy to learn. Long periods of study and supervised

practice are necessary to produce the best results with patients. In the hands of the untrained, failure is bound to result.

In addition to the doctor having knowledge of this method, it is necessary to have two other kinds of professional help. First, there is the nurse, and secondly, there is the physical therapy technician. Each has her part to play and each job is important. The training for the two jobs is quite different. . . .

Training for the physician can be provided in one week. This is needed so that he can properly supervise and direct the work of the nurses and physical therapy technicians.

The National Foundation frequently has been asked how many trained persons should be available in any community. This cannot be easily answered. Certainly every children's hospital and every contagious disease hospital should have at least one doctor and one physical therapist as well as one or more nurses. Training centers have been set up at:

Stanford University, California.

University of Southern California, at Los Angeles. . . .

These all have been furnished funds by the National Foundation, so the tuition costs are very low. Information as to costs, dates of courses and admission policies can be obtained directly from these schools.

Red Cross Sets $125,000 000 As War Fund Needs for 1943.—With a goal of $125 000 000 for its 1943 War Fund, the American Red Cross will embark upon the biggest campaign in its history on March 1.

Millions of volunteers will be recruited to assist in the nation-wide appeal, which will be conducted under the direction of Walter S. Gifford, president of the American Telephone and Telegraph Company, who is national chairman of the 1943 Red Cross War Fund. . . .

"Of the total goal, $45 000 000 is the sum required by Red Cross chapters to finance their indispensable needs and their ever-increasing local work on behalf of families of men in the service. The remainder, or $80 000 000, will go to the national organization which, however, requires one hundred million dollars to finance its national and international program. The difference will be met by a balance of $20 000 000 from the first War Fund of 1942 which will be applied to the 1943 budget."

Chairman Davis emphasized that more than 65 per cent of the amount required by the national organization has been budgeted for Red Cross services to the armed forces.

With the approval of President Roosevelt, March will be observed as Red Cross Month in every city, town, and hamlet covered by the 3,750 Red Cross chapters and their 6,154 branches. All walks of community life will be represented in the campaign.

The customary Red Cross membership Roll Call was dispensed with last November when the Red Cross decided upon one campaign in March which, barring emergencies, will finance its work until February 28, 1944.

Effective Control of Communicable Disease Depends Upon Complete and Prompt Reporting.—Health Officer Uhl of Los Angeles City stated in a recent bulletin that communicable diseases were not being completely reported in the Los Angeles area. The City Health Department had recently made a check on the efficiency of reporting certain diseases and found that in too many instances physicians either neglected to report at all or their reports were incomplete.

"Now more than ever before is complete reporting essential. Epidemic diseases cannot be controlled unless there is prompt isolation of early cases and segregation and observation of susceptible contacts. The Health Department has suffered losses in trained personnel and many additional duties have been imposed, due to the war, but the protection of the public against communicable disease is still first among our responsibilities and we intend to discharge it to the limit of our ability.

"The Health and Safety Code requires that physicians and others promptly report to the Health Officer all communicable diseases, giving name, address, and nature of disease, if known. Any person failing to so report is guilty of a misdemeanor and may be charged with committing a separate offense for each day the violation continues.

"The Health Officer has no desire to prosecute fellow physicians. He does have, however, certain responsibilities and duties to perform, negligence of which makes him subject to legal penalties. It is, therefore, strongly advised that physicians promptly report every case of communicable disease coming to their attention."

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Charity Group Fights $25,000 Salary Limit*

New York, Feb. 2.—A significant warning that the recently imposed $25,000 income ceiling threatens to cripple many charitable, educational and religious institutions was issued today by the New York Infirmary for Women and Children.

The board of directors, headed by Mrs. Frank A. Vanderlip, has voted to appoint a special committee to take up with other hospitals and charities the possibility of a joint appeal to Congress against the $25,000 ceiling.

Based on Charity

A public statement by the Board says:

"Like countless other charitable, educational and religious institutions in America, this hospital probably would never have been created or maintained in a country which had limited opportunity in individual money making efforts.

"The Board unanimously agreed that institutions like the Infirmary may be permanently crippled if contributions were withdrawn by individuals affected by the new ruling.

"Mrs. Vanderlip pointed out that the New York Infirmary for Women and Children, founded ninety years ago by the first woman to receive a medical degree, Dr. Elizabeth Blackwell, with a small donation of $600, has been able to maintain itself through these years by receiving at least two-thirds of its funds through generous donations from individuals.

"The report of the treasurer indicated that the year closed with no deficit. By extreme economies and self-sacrifices the budget of $334,000 was met.

"Patients of the hospital paid in $187,000, with the remaining $147,000 earned through individual donations, United Hospital and Greater New York funds, plus various benefits conducted by the volunteer workers of the hospital board.

Standards Maintained

"The hospital last year cared for 3,563 bed patients and 6,536 dispensary patients. There were 65 active nurses' aides and about 35 other volunteer helpers who contributed 27,572 voluntary hours in 1942, in addition to the work performed by the paid staff of the hospital.

"It was also agreed that its medical efforts and service as a hospital to the community had been maintained at the highest possible standard entirely through the combined efforts of individuals contributing services and funds."

Learning From Disaster

From Boston's tragic night club fire, physicians, and emergency relief organizations have learned a number of lessons which are being transmitted to similar groups in other cities.

In the *Journal* of the American Medical Association, Dr. N. W. Faxon and Dr. E. D. Churchill credit the Wartime Civilian Defense program with having made the

* For editorial reference, see page 58.

community "catastrophe-minded" and with aiding the hospital organization in treating the scores of wounded.

Despite the apparent confusion, "it was obvious to those responsible for organization that every one was acting rapidly, efficiently and intelligently." The doctors found adequate supplies for treating the patients. They suggested that catastrophe organization might well include experts assigned to the scene of disaster to determine the nature of the injury, the presence of noxious fumes and so on, not solely to fix the responsibilities from a legal standpoint, but to aid in the treatment of casualties.

Other recommendations urged concentration of casualties into groups for treatment and organization of hospital staffs into teams for undressing patients, caring for clothes and valuables and treating patients.—Oakland *Tribune*, December 26.

Disaster Lessons Learned In Fire

Boston Doctors Urge Information Service

Chicago (UP.)—Two Boston physicians, reviewing lessons learned in the recent Boston night club fire disaster, recommended today that disaster relief organizations be prepared to supply essential information to medical authorities.

Dr. N. W. Faxon and Dr. E. D. Churchill wrote in the *Journal* of the American Medical Association that the wartime civilian defense program had made Boston's hospital organization "catastrophe-minded" and had aided it in treating the scores of injured.

Rapid and Efficient

Despite the apparent confusion, they said, "it was obvious to those responsible for organization that every one was acting rapidly, efficiently and intelligently." The doctors found adequate supplies for treating all patients.

"One important defect in the casualty organization appeared in an unexpected quarter," Faxon and Churchill said. "It was impossible for those responsible for the care of the survivors to secure adequate information regarding the character of the trauma.

"The predominant clinical pattern of flesh burns and severe damage to the respiratory tract was apparent by 1 a.m. An inquiry was directed to authorities, but no information regarding the disaster could be obtained. The question of poisonous fumes immediately was raised, but definite evidence on this point was lacking.

Urge Quick Autopsies

"Catastrophe organization might well include experts assigned to the scene of disaster to determine the nature of the trauma, the presence of noxious fumes and so on, not solely to fix the responsibilities from a legal standpoint, but to aid in the treatment of casualties. Examination of the dead by competent pathologists well might begin immediately and their findings communicated to clinicians."

The physicians said that the value of a well-organized telephone system also was evident and added that their own system "functioned but can be much improved."

Other recommendations urged concentration of casualties into groups for treatment and organization of hospital staffs into teams for undressing patients, caring for clothes and valuables and treating patients.—Santa Monica *Outlook*, December 24.

Identification Bracelets For Women Urged After Fire

Chicago, Dec. 28.—(AP.)—Recommendations that women wear identification bracelets and that catastrophe organizations include experts on gasses were made today as a result of the Cocoanut Grove holocaust in Boston.

The suggestions were included in a preliminary report in the *Journal* of the American Medical Association by Dr. N. W. Faxon and Dr. E. D. Churchill, director and chief, respectively, of the West Surgical Service of the Massachusetts General Hospital there.

In reporting medical lessons learned from the handling of patients from the night club fire November 28th, which claimed 488 lives, they commented:

"None of the women had anything on their persons that permitted immediate identification. Their outer coats had been deposited in check rooms and they had become separated from their purses and bags.

Bracelet or Anklet

"This suggests the recommendation of a standard method of identification for women by bracelet, anklet or some similar method."

The physicians said that "one important defect in the casualty organization appeared in an unexpected quarter. It was impossible for those responsible for the care of the survivors to secure adequate information regarding the character of the trauma (injury).

"The predominant clinical pattern of flesh burns and severe damage to the respiratory tract was apparent by 1 a.m. An inquiry was directed to authorities, but no information regarding the disaster could be obtained. The question of poisonous fumes was immediately raised, but definite evidence of this point is still lacking.

"Catastrophe organization might well include experts assigned to the scene of disaster to determine the nature of the trauma, the presence of noxious fumes and so on, not solely to fix the responsibility from a legal standpoint, but to aid in the treatment of casualties."

A full report on lung damage, from gases, "must await definite evidence regarding the nature of the products of combustion that were released by the fire," the physicians said.

Other Recommendations

Other recommendations for such disasters included: Immediate examination of the dead by competent pathologists, to guide physicians treating others injured; separation of the living and dead at the very entrance of the hospital; organization and division of doctors and nurses into teams; keeping casualties in one group for concentrated medical treatment; giving an official count and list of identified dead to police and press "as quickly as possible."

"The need for a hospital organization for handling of emergency disasters and the collection of an ample quantity of emergency supplies is obvious," they said.

"Thanks to the efforts of the civilian defense, we had been made 'catastrophe-minded.' Owing to practice mobilization and widespread information regarding disaster management, every one performed his duties without orders. . . . Furthermore, the quantity of supplies on hand proved adequate, and no shortage of anything was experienced.

" 'An emergency anticipated and prepared for ceases to be an emergency.' "—Oakland *Tribune*, December 28.

Painless Childbirth Possible, Doctors Say

Chicago, Jan. 21.—Two physicians today reported successful use of a new method of providing painless, safe childbirth, one of the long sought goals of the medical profession.

The *Journal* of the American Medical Association in which the report appeared, commented editorially that the method "constitutes a real advance in securing relief of pain for mothers during childbirth."

The physicians, Dr. Robert A. Hingson and Dr. Waldo B. Edwards of the U. S. Public Health Service Marine Hospital on Staten Island, N. Y., reported they had used the method in 589 cases, involving 586 live births, "with no maternal complications or deaths."

Their method involves continuous injection of a solution of metycaine, a cocaine substitute, into the lower tip of the spine. It is called "continuous caudal analgesia."

Among the advantages claimed for their method:

1. The patient is not uncomfortable, often enjoys natural sleep and is able to conserve energy.

2. The danger of precipitant birth is minimized. Breech deliveries are greatly facilitated. The premature baby enjoys a better than average chance for survival. There is a noticeable decrease in blood loss.

3. The method can be started in any stage of labor and be continued as long as necessary. Post-delivery complications are reduced. Uterine contractions continue without impediment. The patient remains conscious during delivery.—San Francisco *News*, January 21.

New Painless Childbirth Method Tested Out on Discoverers' Wives

New York, Jan. 21.—(INS.)—The new anodyne which makes childbirth so painless that a mother can read a book while her baby arrives was tested on the wives of the two young physicians who developed the technique, it was disclosed today.

Announcement of the new method called continuous caudal analgesia was made yesterday in Chicago through the American Medical Association *Journal*.

Its devisors, Dr. Robert A. Hingson and Dr. Waldo B. Edwards, employed the method in 589 cases with results "almost 100 per cent" effective.

In the case of Doctor Hingson's wife, it was her first baby and Dr. Donald W. Patrick, one of the attending physicians, said Mrs. Hingson "took the whole thing easily and as a matter of course." She could not appreciate the pain she was being saved, it was said.

Doctor Edward's wife was most enthusiastic as the method was employed as she gave birth to her third

child, and she could realize the suffering it avoided.—San Francisco *Examiner*, January 22.

Heart Disease and Cancer Most Liable to Prove Fatal

Tuberculosis, Pneumonia and Appendicitis Held Most Dangerous for Average Person Decade Ago

Heart disease or cancer, in that order, are more liable to carry you off, when your time comes, than a decade ago, when tuberculosis, pneumonia and appendicitis were more prevalent fatal ailments.

This trend is according to the Bureau of the Census, which yesterday released figures on comparative death causes in California in 1941 and 1931.

Also noteworthy was a drop in deaths from whooping cough, diphtheria, scarlet fever and spinal meningitis—chiefly children's diseases. In 1931 these caused the death of 9.1 persons out of 100,000, and 10 years later only 2.8.

While tuberculosis a decade ago caused 91.1 deaths per 100,000 population, the proportion has dropped to 54.3 per 100,000. Cancer in 1931 took a toll of 127 per 100,000 but in 1941 claimed 148.8, while the figures on heart disease rose from 276.7 to 367.4 per 100,000.

Pneumonia was fatal to 83.9 per 100,000 in 1931, but only 50.4 in 1941. Appendicitis claimed 14.3 per 100,000 a decade ago; in 1941, 7.6. Pregnancy and childbirth diseases dropped from 8.7 in 1931 to 4.1.

Homicides, suicides and nontraffic deaths were lower, but traffic deaths were higher in 1941, the figures showed. —Los Angeles *Times*, January 21.

Warren Orders Probe of Chiropractic Board

Sacramento, Jan. 22.—(INS.)—Admitting "something is doing" regarding the State Board of Chiropractic Examiners, Governor Warren revealed today the attorney general and the district attorney of Los Angeles County had been asked to investigate the board.

"It has developed," Warren charged, "that the board has been giving examinations not as a board but as individuals of the board.

"This matter is being investigated by the attorney general, who in turn some days ago placed the matter in the hands of the district attorney of Los Angeles County."

Warren said further details were in the hands of Attorney General Robert W. Kenny and John Dockweiler, district attorney of Los Angeles County.—San Francisco *Call-Bulletin*, January 22.

Chiropractic Board Accused of Taking Fees

Warren Charges Some Members Charged $100 for Special Examination for License

Some members of the Olson appointed State Board of Chiropractic Examiners have been giving examinations as individuals, charging $100 and pocketing the money, Governor Warren charged at Sacramento yesterday.

He disclosed that Attorney General Robert Kenny is investigating the board with the assistance of the district attorney at Los Angeles and that the president of the board has resigned.

Replying at his press conference to a question as to whether the board was under scrutiny, the Governor said:

"Since you ask me, the answer is yes.

"I am sorry that I cannot give you accurate details. However, it has developed that the chiropractic board has been giving examinations not as a board but as individuals on the board."

Charging $100 Apiece

"It also has developed that at least a majority of the board has been charging applicants $100 apiece, the $100 going not to the State but to members of the board.

"It also has developed that the questions to be asked were put in a position where the applicant could see them beforehand.

"It also is my information—I cannot say positively—that everyone who took the examination this way and paid the $100 passed.

"I have not requested any resignations. I am awaiting the action of the attorney general and the district attorney. I am informed that one member of the board admits giving twelve such examinations."

Kenny, confirmimng the investigation at his office here, said the inquiry is centered in Southern California. . . . —San Francisco *Examiner*, January 23.

New Mental Clinic Set Up

Los Angeles Making Effort to Cope With Nervous Diseases

Los Angeles is making a start in the prevention of nervous and mental diseases, currently on the upswing because of war tensions, it was learned yesterday when Olin Wellborn III, president of the Council of Social Agencies of Los Angeles, announced the establishment of this community's first psychiatric clinic for adults.

The clinic, at Cedars of Lebanon Hospital, is financed on a one year demonstration basis by a special grant of Community Chest funds authorized by the Community Welfare Federation.

Volunteer Board

Known as the Los Angeles Psychiatric Service, the clinic is operated by a volunteer board of directors composed of business, professional and civic leaders interested in social welfare. Dr. Glenn Myers is chairman of the board.

Although war has increased the number of mental and nervous breakdown cases, Wellborn made it plain that the present psychiatric program is not being undertaken strictly as an emergency measure.

"The need existed long before the war," he said. "What was a vital need in peacetime has merely become a wartime necessity."

List of Directors

Members of the board of directors of the new clinic are E. Vincent Askey, M. D., City Board of Education; Milton Baruch, building contractor; LeRoy Bruce, director, Los Angeles County General Hospital; Mrs. Ernest A. Bryant, Jr., Los Angeles Visiting Nurse Association; Philip M. Connelly, Los Angeles Industrial Union Council; Mrs. Blythe Francis, executive secretary, Family Welfare Association of Los Angeles; Fred S. Hilpert, vice-president, Farmers & Merchants National Bank; Mrs. Ruby Inlow, graduate school of social work, S. C.; Arlien Johnson, Ph.D., graduate school of social work, University of Southern California; Walter Mezger, superintendent, Cedars of Lebanon Hospital; Msgr. Thomas J. O'Dwyer, Catholic Welfare Bureau; Ray W. Smith, manager, Downtown Business Men's Association: Mrs. Sumner Spaulding, Council of Social Agencies; Ellen Sullivan, Ph.D., psychology department, University of California at Los Angeles; Walter Treadway, regional director, United States Public Health Service, and Eugene Ziskind, M. D.—Los Angeles *Times*, January 18.

Hospital Ward Grant Sought in San Bernardino

An outright grant of $68,500 to finance the proposed construction of an isolation ward at San Bernardino county's hospital was requested today by the board of supervisors in an application to the defense public works administration.

The board some months ago submitted a request for a $50,000 grant but the estimates of experts of the U. S. Public Health Bureau, who proposed the construction of the ward to replace the existing facilities at the hospital, were increased in a revised program.

Under the U. S. Public Health Bureau's proposal, the Federal government would construct the ward which would serve both the general public and soldiers in the district in the event of an epidemic of contagious disease.—San Bernardino *Telegram*, January 4.

U. S. Syphilis Rate Estimated

Chicago, Dec. 24.—(UP.)—Of every 1,000 men in the nation between the ages of 21 and 35, an estimated 47.7 have syphilis, it was reported today in the *Journal* of the American Medical Association.

This estimate is based on serologic blood test reports of 1,895,778 white and Negro men between these ages tested under provisions of the Selective Service Act.

More city men were found to be afflicted than men from rural areas. The highest prevalence rates in the study were found in the Southeastern states. The rates rise sharply with increasing age. It was explained that this is due to a constantly accumulating backlog of uncured syphilis.—San Francisco *News*, December 24.

Stanford Doctor Describes Powerful New 'Pep Pill'

Drug Routs Sleep and Weariness

A powerful new sleep-preventing "pep" pill which can keep a man fully alert for 18 to 24 hours was described by a Stanford University pharmacology professor today.

Dr. Maurice Tainter told a meeting of the Society of Experimental Biology and Medicine in San Francisco that only one ten-thousandth of an ounce of the drug, methylbenzedrine (a derivative of the commonly known benzedrine), produces unmistakable stimulation which makes a person think more clearly and react faster hour after hour until the effect wears off, permitting normal sleep.

A dose of three to four thousandths of an ounce, he said, will prevent sleep for 24 hours, but causes nervousness. A larger amount may be fatal.

The substance is roughly 80 times as strong as the caffeine in coffee and twice as potent as adrenalin or ordinary benzedrine, Dr. Tainter explained.

Dr. Tainter said he and Dr. Armando Novelli, who worked at the faculty of medicine in Buenos Aires, Argentina, had been experimenting with methyl-benzedrine since 1938.

Germany and Denmark also have been working on the drug, and Dr. Tainter said there have been indications that methyl-benzedrine pills have been given German aviators and tank crews to enable them to perform seemingly superhuman tasks of endurance.

The drug has been used to treat victims of nervous breakdown and persons who are dull and depressed or "can't wake up in the morning." In Europe, patients given the preparation have recuperated more quickly after operations, he said.—Palo Alto *Times*, December 24.

Dr. J. B. Harris Heads Medical Academy

Dr. Junius B. Harris has been elected president of the California Academy of Medicine to succeed Dr. Loren Chandler, dean of the Stanford Medical College. Drs. Dan Moulton of Chico, Butte County, and George Sanderson of Stockton, San Joaquin County, were named on the executive committee.

The California Academy of Medicine was formed in 1870.—Sacramento *Bee*, January 14.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Legal Relationship of Physician and Patient as Affecting Business Transactions Between Them

The legal relationship existing between physician and patient is universally characterized by the courts as being one of trust and confidence, similar in this respect to the relationship of attorney and client or trustee and beneficiary. By reason of this confidential relationship, certain implications arise with respect to all transactions between the parties and as was said in *Cole v. Wolfskill*, 49 Cal. App. 54: "Once this relationship is shown to exist all dealings between the parties will be closely scrutinized to ascertain whether the confidence of the trusting party (the patient) has been betrayed or his mind unduly influenced to his prejudice."

The courts not only subject business dealings between physician and patient to a careful examination whenever their validity or freedom from fraud is questioned, but take the further step of basing a presumption of undue influence on the legal relationship of physician and patient, and wherever it is shown that a physician was presented with some opportunity for deception, such as weakness of intellect on the part of the patient or advanced years, the court will presume that the physician practiced a deception or acted unconscientiously. The net result of this presumption is that the burden is cast upon the physician to prove that in the particular transaction the patient acted intelligently and with full knowledge of the consequences of his act. This theory of the law, reasonable or unreasonable as it may be in the particular case, comes into play whenever a patient takes some action beneficial to the physician, such as making him a devisee or legatee in his will, or deeding property to him.

An illustration of the doctrine is presented by the case of *MacCaulay v. Booth*, 53 A.C.A. 968, decided August 1, 1942. There the patient was suffering from a number of serious ailments and in the early part of 1937 moved from his city residence to a country locality where the defendant physician undertook his treatment, the relationship of physician and patient existing from May, 1937, until the death of the patient in January, 1938. During this period, the attendance of the physician was very frequent, amounting to several visits each week and the treatment was extensive. The evidence adduced at the trial was to the effect that the patient was in financial difficulty and therefore unable to make payment for the medical services rendered in the usual manner, and that, accordingly, he executed and delivered to the physician a promissory note in an amount slightly exceeding $1,000.00, representing the obligation due the physician for medical services rendered from May, 1937, to January, 1938. The promissory note was secured by a deed of trust upon the premises in which the patient resided and the entire transaction took place the day before the patient's death. The requisite papers were prepared by the patient's attorney and were signed and delivered in the presence of the physician, the attorney and the plaintiff in the instant case, who filed suit after the death of the patient to cancel the trust deed and promissory note.

The plaintiff held a deed of gift of the property executed by the patient some time prior to his death and prior to the deed of trust delivered to the physician and filed suit to set aside the physician's deed on the grounds that the patient was entirely without understanding at the time of the execution of the instruments and that the physician as such had failed to respect the confidential relationship existing between the patient and himself and had gained an unfair advantage in the transaction.

The evidence introduced in the trial court showed that the plaintiff had assisted the patient in signing the necessary papers and that the plaintiff as well as the patient's attorney had been there during the entire transaction and neither had raised any objection at the time. The evidence on the patient's competency at the time was contradictory, but the trial court rendered judgment in favor of the defendant physician, upholding the validity of the promissory note and the deed of trust which he held.

On appeal, the District Court affirmed the judgment holding that the evidence was sufficient to overcome any presumption of undue influence on the part of the physician. The Court reiterated

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

the rule that the confidential relationship between physician and patient necessitates a close examination of all dealings between such parties in order to protect a person in a weakened condition peculiarly subject to suggestions on the part of his physician in whom he must repose a certain amount of confidence and trust. It was held, however, that independent advice was not indispensable to negative the presumption of undue influence. This presumption the court pointed out is by no means conclusive and if at the trial the physician produces sufficient evidence that the patient acted voluntarily and with a full appreciation of the consequences of his act, the transaction will be sustained notwithstanding the confidential relationship.

LETTERS†

Concerning Medical Literature to Station Hospitals of Military Camps Located in California

Editor's Note.—In the January issue, report was given and comment made concerning medical journals and books sent by the C.M.A. Postgraduate Committee, to Colleagues in Military Service. (January CALIFORNIA AND WESTERN MEDICINE, page 3.) A letter from the Postgraduate Committee to Medical Officers in Command appears below. Also some replies:

CALIFORNIA MEDICAL ASSOCIATION

Scientific Assembly: Committee on Postgraduate Activities

San Francisco, January 29, 1943.

To: *The Medical Officer in Command.*

STATION HOSPITAL

————, California

FROM: *C.M.A. Postgraduate Committee.*

SUBJECT: *"California and Western Medicine," official journal of California Medical Association.*

Dear Doctor:

Because your Camp is located in California, members of your Hospital Station may be interested in scanning the pages of CALIFORNIA AND WESTERN MEDICINE, official journal of the California Medical Association.

The C.M.A. Postgraduate Committee has arranged to have your Camp placed on the *complimentary mailing list of C. and W. M.*, to permit the JOURNAL to be available in your Station library.

The roster of County Medical Societies appears in each issue, in the front advertising section, on advertising page 4. We know that the members of the local society of the county in which your own Camp is located, will be glad to have members of your own staff feel free to attend and take part in county society meetings.

We also take the liberty of calling your attention to the addresses of the medical libraries in California, on advertising page 5.

Medical news, of a military nature, appears in each issue of C. and W. M., under the caption, "California Committee on Participation of the Medical Profession in the War Effort."

With good wishes, and hoping you will feel free to inform us if, at any time, you think we can be of service.

Cordially and fraternally,

C.M.A. POSTGRADUATE COMMITTEE
By GEORGE H. KRESS, M. D.,
Secretary-Editor.

* * *

STATION HOSPITAL
OFFICE OF THE SURGEON
Fort ————, California
February 1, 1943.

Dear Dr. Kress:

Thank you very much for your letter of January 29, 1943, and for the copies of CALIFORNIA AND WESTERN MEDICINE which were received some time ago.

Several members of our staff are California doctors, and they, as well as the rest of us, will enjoy and profit by perusing your journals, I am sure.

Thanking you again for the sentiments expressed in your letter of January 29th, I am,

Yours sincerely,
(Signed) ————,
Colonel, Medical Corps,
Surgeon.

* * *

STATION HOSPITAL
OFFICE OF THE SURGEON
———— Flying School
————, California
February 1, 1943.

To: *C.M.A. Postgraduate Committee,*
San Francisco, California.

Gentlemen:

Your letter of January 29, 1943, in which you have stated that this camp has been placed on the complimentary mailing list of C. and W. M., has been received and I wish to thank you for the staff, as a whole, for your consideration, and am quite sure it will aid considerably in keeping contact with the medical world outside.

You may be assured that you will be called upon if, at any time, we think you can be of service. Also, the libraries will be used frequently.

Cordially and fraternally,
(Signed) ————,
Major, Medical Corps,
Surgeon.

* * *

———— A.A.F. FLYING TRAINING DETACHMENT
OFFICE OF THE SURGEON
————, California
December 28, 1942.

SUBJECT: *Medical Literature.*

To: *California Medical Association, 450 Sutter Street, San Francisco, California.*

1. In receipt of copy of C. & W. M., and letter your office, dated December 24, 1942, same subject, both of which are sincerely appreciated.

2. This effort as presented on page 230, October issue of C. & W. M., in our opinion will be equally appreciated by all Medical Officers in the Armed Forces. The C. & W. M. itself contains considerable information of interest to both of us, and we shall be very highly appreciative if we can be kept on its mailing list.

3. It so happens that Dr. ——— prior to entering into the Armed Forces has been a pathologist, and myself, an E.E.N.T. Specialist, and we would both sincerely appreciate literature on these respective subjects, if it can at all be possible.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

4. Once again, may I extend our sincerest thanks for the literature also received, and for the consideration your society has shown us Service men in this effort, and I feel certain that our feelings are shared by all the other Army Medicos fortunate enough to receive the same consideration.

(Signed) ————,
Captain, Medical Corps,
Surgeon.

* * *

HEADQUARTERS ———— AIR FORCE
OFFICE OF THE SURGEON
December 31, 1942.

My dear Doctor:

The volume of Gray's Anatomy, which was sent by your library, has recently been received in this office. It will make a very welcome addition to our present rather meager medical library and I can assure you that its receipt is very greatly appreciated.

Very sincerely yours,
(Signed) ————,
Colonel, Medical Corps,
Surgeon.

* * *

STATION HOSPITAL
ARMY AIR FORCES ADVANCED FLYING SCHOOL
————, California
January 13, 1943.

California Medical Association,
450 Sutter Street,
San Francisco, California.

Gentlemen:

This Station Hospital has again received medical books sent by you. The staff wishes to again thank the California Medical Association for this donation. Your efforts on our behalf are greatly appreciated.

Very truly yours,
(Signed) ————,
Major, Medical Corps,
Executive Officer.

Concerning Proposed Amendments to Medical Practice Act

(COPY)
State of California
Department of
PROFESSIONAL AND VOCATIONAL STANDARDS
Board of Medical Examiners
Sacramento, California, January 8, 1943.
Re: Temporary licenses.

Dear Doctor Kress:

Some indication of the difficulties which will confront California in case a measure is supported authorizing the issuing of temporary licenses will be found in an article by S. D. Van Meter, former secretary of the Colorado Board, which article was printed in the American Medical Association *Journal* of February 3, 1906, and was entitled "Medical Forgeries."

The Council on Medical Education of the American Medical Association in their Bulletin No. 19, entitled "Correspondence, Edward Dowdall and James C. Jones" further bring out our point. The medical licensure literature is filled with cases where imposters endeavored to obtain a medical license on fraudulent credentials.

The undersigned had the following articles published in the *Bulletin* of the Federation of Medical Examining Boards:

1. Carnagey College of Medicine (Fraudulent).
2. Eligibility for a License.
3. The National University of Belgium.
4. A Prison-Hatched Diploma Mill.
5. Safeguarding State Board Records.
6. A Study in Diplomas.
7. Legal Checks in California on the Practice of Medicine.
8. Uniform Standards of Licensure.
9. Samuel A. Cheatham.
10. Philip Dyment.
11. Galen R. Hickok.
12. Peter Le Roux, alias "Dr. Alf. A. Hesse".
13. Hamilton McClarty.
14. George Timothy O'Sullivan.
15. Arthur Edmund Webb.

The proposed legislation must be drawn very carefully; otherwise it will prove to be a boomerang.

Very truly yours,
(Signed) C. B. PINKHAM, M. D.
Secretary-Treasurer.

Concerning Procedure in Application for Registration

(COPY)
BOARD OF MEDICAL EXAMINERS OF THE
STATE OF CALIFORNIA
January 5, 1943.
Re: Application.

Dear Doctor:

We are still awaiting the receipt of a certified copy of a letter written by the Northwestern University Medical School to the Illinois Department of Registration and Education prior to your admission to their examination, said letter stating that you had passed all of your final examinations at the time of admission to examination and had fulfilled all of the medical school requirements for the issuance of your medical diploma. This certified copy of letter is necessary inasmuch as you were admitted to examination in the State of Illinois sometime prior to your having been granted the degree "Doctor of Medicine" by Northwestern University Medical School.

You would not have been admitted to examination for a license to practice in the State of California unless you were the possessor of a medical diploma. The California law requires that the State which issued the license used as the basis of application must have maintained a standard equal to California on the same date. In your particular instance the Illinois Board did not fulfil this requirement inasmuch as they admitted you to examination on June 28, 1927, whereas your medical diploma bears the date June 18, 1928.

We return herewith enclosed pages 1 and 2 of a supplemental reciprocity application drawing your attention to your failure to complete same in accordance with the printed instructions.

Awaiting your pleasure, believe me,
Very truly yours,
C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Concerning California Legal Procedure in re: Foreign Medical Graduates*

December 30, 1942.

Dr. ————,
Addressed.

Subject: Yours of December 21st.
Re: Application.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Dear Doctor:

This will acknowledge receipt of your letter advising you hold an M. D. degree issued in 1922 by the ——— University, and that you were licensed to practice in the State of New York in December, 1942.

Enclosed herewith please find our printed form 172-173 which will give you full information as to California's requirements exacted of graduates of foreign medical schools. You will notice on our form 173 information relative to reciprocity. If, prior to your admission to the New York medical board examination, you did not fulfill all of California's requirements exacted of foreign medical school graduates, you will not be acceptable on a reciprocity basis.

Your letter relates that you have had "three months at the Hospital of St. Anthony of Padue, in Chicago, Illinois." This institution is on the approved list. However, in addition to other requirements, it will be necessary for you to complete a one-year internship in that hospital prior to your being eligible for admission to examination in the State of California.

Awaiting your compliance with the statutory provisions as outlined on the enclosed printed form 173, believe me

Very truly yours,
(Signed) C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Concerning a Spurious Check-Passer

January 13, 1943.

To the Editor:

This letter is sent to call attention to a check-passer who is evidently operating in California cities. His method of procedure in mulcting doctors is somewhat as follows:

He enters a doctor's office, states his wishes to have a Wassermann Test made, and before starting the work, begs to be excused because his automobile is parked and he wishes to change its location. In this way, he gives the impression of having means (a build-up).

In paying for his Wassermann, he states he also wishes to pay at the same time for his wife and daughter who will come in later, and offers a check in excess of the amount due. He will take such cash as the doctor has on hand. If it is not enough to cover the difference in the amount of the check and the total amount due, he tells the physician to give the remainder to his wife when she comes in.

Upon presentation at the bank, the check is found to be of no value.

It is requested that if this individual puts in appearance anywhere, the local police officials be promptly notified.

Very truly yours,
———, M. D.

Concerning Possibility of Malpractice Suits in Military Services*:

AMERICAN MEDICAL ASSOCIATION
Bureau of Legal Medicine and Legislation

Dear Dr. Kress:

I have received your recent letter with respect to the advisability of physicians who enter military service continuing malpractice insurance.

The editorial discussion of the matter that appeared in *The Journal* for September 13, 1941, is the only reference to the situation that has been published in *The Journal* of the A.M.A. I think that editorial covers the situation adequately. While there is no principle of law with which I am acquainted that exempts a physician in military service from liability for injuries inflicted on service patients due to negligent treatment, it must be admitted that the instances in which physicians in service are sued for malpractice are few and far between. I had some correspondence some time ago about this matter with the Office of the Surgeon General of the Army and my impression as to the infrequency of suits against physicians in service is based on that correspondence. As a matter of fact, the editorial in *The Journal* reflected the information that I received from the Office of the Surgeon General. In addition, I talked the matter over personally with Brigadier General McAfee and he could recall only one instance in which a member of the Medical Corps of the Army was sued for malpractice and that one case never came to trial.

Since there is a possibility of a suit being instituted, I personally believe that a physician in service should carry some type of malpractice protection. The insurance companies, as you know, themselves realize that the possibility of suit being instituted against a physician in service is relatively remote and express that realization by offering protection at a lower premium rate.

Incidentally, there came to my notice just a few days ago a suit that had been instituted against a physician in the United States Public Health Service by a patient who had been treated by the physician in a hospital operated by the Service. The patient in this case was not a member of the military forces but a civilian. This instance does indicate, however, that physicians in the service of the government are not immune from malpractice suits.

To summarize, the situation seems to be about this. Malpractice suits against physicians in military service are extremely rare. If a suit is instituted in a State court it may be removed to a federal court and defense will be supplied by a United States Attorney. If the suit terminates unfavorably to the physician, the obligation of paying the judgment rests on the physician involved, since there is no provision under which the Federal Government may assume any ultimate liability for damages. Since premium rates are being reduced to cover protection of physicians in military service, it is my view that insurance should be carried even though the possibility of suit be remote.

Sincerely yours,
(Signed) J. W. HOLLOWAY, JR.

Concerning Food Requirements of Hospitals in Southern California:

California Medical Association, *Addressed.*

Sirs:

This to call your attention to the following:

An unbalanced distribution, and unbalanced price ceiling and lack of awareness of hospital food requirements has penalized many hospitals in Southern California.

We of the hospital field are urging (1) *food rationing;* (2) an understanding and admission of hospital needs; and (3) an equitable distribution of food allotments for both *public* and *private* hospitals. (O.P.A. regulations now permit public hospitals an edge.) (4) A basic price ceiling for all areas subject to differences of transportation and distribution costs.

Your endorsement would greatly assist us.

(Signed) A. J. WILL.

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* See also CALIFORNIA AND WESTERN MEDICINE, October, 1942, on page 278.

* See also CALIFORNIA AND WESTERN MEDICINE, June, 1942, on page 380.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 2, February, 1918

EXCERPTS FROM EDITORIAL NOTES

Annual Meeting at Del Monte.—The annual meeting of the California State Medical Society will be held at the Del Monte Hotel, April 16, 17 and 18, 1918. A program of timely and unusual interest is being prepared. The place and season of the meeting insure a splendid outing for every doctor in attendance. Special announcements and a tentative program will be published next month. It should be the pleasure of every doctor in the State to attend this meeting if he can possibly do so. He is the one who will profit most by attendance. Give the matter serious thought and make your reservations early.

Scientific Program.—A large number of good papers have been secured for the coming meeting at Del Monte and a tentative program will be published in next month's JOURNAL. Naturally in these times various problems connected with the War work are of paramount interest, and accordingly arrangements have been made to have the same presented. There will be sufficient variety to the subjects, however, to insure the presentation of a program of unusual value and interest.

Insurance and the Indemnity Defense Fund.—We have been greatly surprised to learn that some of our members are under the present impression that the Council and Legal Department of the Society have recommended to the members that their insurance be dropped upon joining the Indemnity Defense Fund.

This is erroneous. Neither the Council nor the Legal Department has at any time advocated such a course. On the contrary, our Legal Department has at all times cautioned members who were carrying insurance to continue the insurance, and has recommended that they join the Fund as well; but as to all members who had no insurance, the recommendation has been that they join the Fund. . . .

Therefore, as we have heretofore said, and we thought with sufficient plainness, and which we here repeat, the Society does not advise any member to cancel or give up his insurance upon becoming a member of the Fund, but on the contrary, to continue his insurance and to join the Fund as well. . . .

Editorial Comment.—Why should not every doctor in the United States who is mentally, physically and morally fit, be in the M. R. C.? In the immediate future the Medical Reserve Corps must be immensely augmented; and so as to enable the Surgeon General to have at his command for immediate assignment, as conditions demand, a sufficient number of trained medical officers, let us take the above thought seriously. The German war depends for its success as much upon the medical profession, as upon the combatant forces, and while we do not know that any such intention, as herein suggested, is in the mind of the Surgeon General, it would at least give him the necessary corps of medical officers from which to draw, and would serve the best interests of our country, and the best interests of the medical officers themselves.

(Continued in Front Advertising Section, Page 22)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

News

"Some members of the Olson appointed State Board of Chiropractic Examiners have been giving examinations as individuals, charging $100 and pocketing the money, Governor Warren charged at Sacramento yesterday. He disclosed that Attorney General Robert Kenny is investigating the board, with the assistance of the District Attorney at Los Angeles, and that the President of the board has resigned. Replying at his press conference to a question as to whether the board was under scrutiny, the Governor said: 'Since you ask me, the answer is, yes. I am sorry that I cannot give you accurate details. However, it has developed that the chiropractic board has been giving examinations not as a board but as individuals on the board. It also has developed that at least a majority of the board has been charging applicants $100 apiece, the $100 going not to the State but to members of the board. It also has developed that the questions to be asked were put in a position where the applicant could see them beforehand. It also is my information—I cannot say positively—that everyone who took the examination this way and paid the $100, passed. I have not requested any resignations. I am awaiting the action of the attorney general and the district attorney. I am informed that one member of the board admits giving twelve such examinations.' . . . Dr. Charles E. Barrows of Los Angeles, board president, who resigned as a result of the investigation, admitted most of the Governor's charges. But he denied any implication of wrong-doing. He said: 'The board voted last July to do this (individual examinations) to help the war effort, as a patriotic gesture, for those applicants who were ready for their examination and expected to be called into military service before the next examining period. Because there is a lot of work attached to conducting such special examinations, the board authorized the examiner to charge $100; to those who were going into the service and wished to be examined at once and wished to pay $100, that would be the charge—there was nothing compulsory about it.' The $100 was in addition to the $25 fee due the State from each applicant, he said. He estimated that about forty such examinations were given, and that he conducted twenty of them. There was no cribbing, he declared. Dr. Eugene W. Hitchman of San Jose, another member of the board, said he knew nothing of the Governor's charges." (San Francisco *Examiner*, January 20, 1943.)

"Dr. E. W. Merrithew, prominent Martinez physician, is free on bail today after his arrest by California highway patrolmen, on a charge of driving while drunk. . . ." (Oakland *Post-Enquirer*, January 2, 1943.)

"Dr. Vincent P. Carroll, Laguna Beach, and Dr. Glen D. Cayler, Los Angeles, today were reappointed by Governor Culbert L. Olson to the State Board of Osteopathic Examiners. . . ." (Oakland *Post-Enquirer*, December 21, 1942.)

(Continued in Back Advertising Section, Page 36)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.